



**Uniform  
Medical Plan**

Your health. Your plan. Your choice.

# **Billing & Administrative Manual**

for Hospitals

Visit the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) to download the latest version of this manual, and all other UMP publications mentioned in this document.

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**Washington State  
Health Care Authority**  
*Public Employees Benefits Board*



**Washington State Health Care Authority**

PO Box 91118 ■ Seattle, WA 98111-9218

206-521-2000 ■ Fax 206-521-2001 ■ TTY/TDD 360-923-2701

[www.ump.hca.wa.gov](http://www.ump.hca.wa.gov)

Dear Provider:

Thank you for participating in the Uniform Medical Plan (UMP) provider network(s). Enclosed are billing instructions that we hope you will find helpful. UMP is a self-insured, preferred provider medical plan designed by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA). Our motto—“*Your health. Your plan. Your choice.*”—reflects UMP’s philosophy, emphasizing freedom of choice paired with enrollee responsibility for care management.

UMP offers one of the largest published provider networks in the state of Washington, as well as a nationwide retail pharmacy network with a mail-order option.

Since UMP’s benefit structure requires cost-sharing on the enrollee’s part, this works to promote the responsible use of health care resources. UMP encourages providers and enrollees to work together to achieve optimal health outcomes at an acceptable cost. In today’s environment, many health care consumers covered by insurance are not aware of the true cost of health care services; UMP’s cost-sharing structure tends to enhance awareness.

In addition to our statewide Preferred Provider Organization (PPO) network and coverage, UMP also administers UMP Neighborhood for residents of King, Pierce, and Snohomish counties. In UMP Neighborhood, patients receive most health care services through a “care system” (a more limited choice of network providers) that they select when they enroll.

Please take the time to review this *UMP Billing & Administrative Manual*, as well as our current *Certificates of Coverage (COCs)* and *Preferred Drug List* for UMP PPO and UMP Neighborhood. Information pertaining to UMP Neighborhood is included in this manual in Appendices A-3 to A-5.

You may also access these documents, fee schedules, and other information by visiting our Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov). In addition, the Web site includes our network provider directories for UMP and UMP Neighborhood. UMP also gives providers online access to secure information (such as enrollee eligibility and payments toward the annual deductible, and claims status) through OneHealthPort. For more information, go to [www.onehealthport.com](http://www.onehealthport.com) or click on the links from our Web site.

If you have any questions regarding UMP policies and procedures, fee schedule information, or if you need additional training, please do not hesitate to call us toll-free at 1-800-292-8092, or locally at 206-521-2023. To confirm patient eligibility, call toll-free 1-800-335-1062; you will need to have the subscriber identification number to access eligibility information. When prompted by the automated system, you should choose the number which selects “PEBB subscriber information.”

We are pleased to have you as a network provider, and look forward to working with you to provide quality care and customer service to all of our enrollees.

Sincerely,

Janet Peterson  
Executive Director

Malcolm M. Dejnozka, M.D.  
Medical Director

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## Section I

# Quick Reference Notes

### 1.1

## How to Reach Us

Uniform Medical Plan Web site  
[www.ump.hca.wa.gov](http://www.ump.hca.wa.gov)

### 1.1.1

## Addresses and Phone Numbers

### Uniform Medical Plan Customer and Provider Services

- Benefits information
- Claims status and information
- Enrollee eligibility information\*
- General billing questions
- Interactive Voice Response (IVR) system
- Medical review
- Notification/preauthorization
- Verify provider's network status

**Uniform Medical Plan**  
**P.O. Box 34850**  
**Seattle, WA 98124-1850**

#### Provider Services

Toll-free ..... 1-800-464-0967  
Local..... 425-686-1246  
Fax ..... 425-670-3199

#### Active Enrollees

Toll-free ..... 1-800-762-6004

#### Retired Enrollees

Toll-free ..... 1-800-352-3968

#### **\*Automated Enrollee Eligibility Information**

Toll-free 1-800-335-1062 (Have subscriber I.D. number available, and select #2 for "PEBB subscriber information.")

### Case Management Services

Toll-free ..... 1-888-759-4855

### Electronic Claims Submission

The following clearinghouses frequently submit claims electronically to UMP.

#### Electronic Network Systems

**[www.enshealth.com](http://www.enshealth.com)**

Toll-free ..... 1-800-341-6141

#### Emdeon Business Services™

(formerly known as WebMD)

**[www.emdeon.com](http://www.emdeon.com)**

Toll-free ..... 1-877-469-3263

#### MedAvant Healthcare Solutions

(formerly known as ProxyMed)

**[www.proxymed.com](http://www.proxymed.com)**

Toll-free ..... 1-800-586-6870

#### The SSI Group

**[www.thessigroup.com](http://www.thessigroup.com)**

Toll-free ..... 1-800-880-3032

## Provider Credentialing and Contracting Issues

- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- Network provider applications and contract information
- New provider enrollment
- Policies and procedures
- *Provider Bulletin* feedback

#### Uniform Medical Plan

**P.O. Box 91118**

**Seattle, WA 98111-9218**

Toll-free ..... 1-800-292-8092

Local..... 206-521-2023

Fax ..... 206-521-2001

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## Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians Network

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- Network provider applications and contract information
- Billing procedures
- Fee schedule and payment policy information

### American WholeHealth Networks

(Axia Health Management; formerly Alternäre)

Toll-free ..... 1-800-274-7526  
1-800-500-0997

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## Prescription Drugs (retail and mail-order)

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- Benefits information
- Claims information
- Cost share information
- Eligibility verification
- Preferred drug list information
- Prior authorization requests
- Network pharmacy information (location and network verification)

### Express Scripts, Inc.

Toll-free ..... 1-800-763-5502

### To fax prescriptions (providers)

Toll-free ..... 1-800-396-2171

*Must be faxed on provider's letterhead*

### To call in prescriptions (providers)

Toll-free ..... 1-800-763-5502

### Preauthorization of prescription drugs

Toll-free ..... 1-800-417-8164

Fax ..... 1-877-697-7192

### Appeals and Correspondence

Toll-free ..... 1-800-417-8164

Fax ..... 1-877-852-4070

### Express Scripts, Inc.

Attn: Pharmacy Appeals: WA5

Mail Route BLO390

6625 West 78th Street

Bloomington, MN 55439

## Vendor for Specialty Prescription Drugs

### CuraScript

To call in prescriptions for specialty drugs

Toll-free ..... 1-866-413-4135

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## Tobacco Cessation Services

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### Free & Clear

Toll-free ..... 1-800-292-2336

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## 1.1.2

## Web Site Information

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### Uniform Medical Plan

[www.ump.hca.wa.gov](http://www.ump.hca.wa.gov)

- *Billing & Administrative* manuals
- *Certificates of Coverage* (benefits books)
- *Network Provider Directory*
- *Preferred Drug List*
- *Professional Provider Fee Schedule*
- *Ambulatory Surgery Center Fee Schedule*
- *Anesthesia Fee Schedule*
- *Chiropractor Fee Schedule*
- *Prosthetic and Orthotic Fee Schedule, Including Ostomy and Urological Supplies*
- All-Patient Diagnostic Related Group Weights used for Hospital Inpatient Reimbursement
- Other important UMP information

### OneHealthPort

[www.onehealthport.com](http://www.onehealthport.com)

- Register with OneHealthPort for access to secure online services and e-mail to manage your UMP business

### U.S. Preventive Services Task Force Guidelines

[www.ahcpr.gov/clinic/gcpspu.htm](http://www.ahcpr.gov/clinic/gcpspu.htm)

- Preventive care guidelines

### Centers for Disease Control's National Immunization Program

[www.cdc.gov/nip/publications/ACIP-list.htm](http://www.cdc.gov/nip/publications/ACIP-list.htm)

### Express Scripts, Inc.

[www.express-scripts.com](http://www.express-scripts.com)

- General prescription drug information

**Note:** See the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) for UMP-specific information on prescription drugs.

## Free & Clear

[www.freeclear.com](http://www.freeclear.com)

- Tobacco cessation program information

## American WholeHealth Networks

(Axia Health Management; formerly Alternäre)

[www.wholehealthpro.com](http://www.wholehealthpro.com)

- Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians—network provider resources information

## 1.2

# Sample Uniform Medical Plan Identification Card

This is the identification card that confirms UMP Preferred Provider Organization (UMP PPO) enrollment. Each UMP PPO enrollee is issued an identification card with a unique 9-digit number prefixed by a “W.” Please note that UMP does not use social security numbers for eligibility and claim records. Please use the “W” number on all claims and inquiries.

A sample of the UMP Neighborhood identification card is included in Appendix A-3, Section 1.2.

	<b>Uniform Medical Plan</b> <small>Your health. Your plan. Your choice.</small>	Preferred Provider Organization (PPO)
<hr/>		
<b>Enrollee Name:</b> JOE EMPLOYEE		
<b>Subscriber ID No:</b> W123456789		
<b>RxBin:</b> 003858 <b>RxPCN:</b> A4 <b>Rx Group:</b> WA5A		
<hr/>		
You must present this card when you use a network provider and at participating pharmacies for direct claim filing and the most cost-effective services.		
		
<hr/>		
BEECH STREET CORPORATION NATIONWIDE PPO AND AFFILIATED NETWORKS		
		
		
LA, MS	AL	IA, NE
MT	WV	AR

The card does not guarantee coverage. To confirm eligibility or obtain benefit information and requirements for prior approval, contact the plan at 1-800-762-6004 or in Seattle at 425-670-3000.
<hr/>
<u>To find a network provider:</u>
<ul style="list-style-type: none"><li>• <b>In Washington and Idaho:</b> counties of Bonner, Kootenai, Latah and Nez Perce -- <a href="http://www.ump.bca.wa.gov">www.ump.bca.wa.gov</a> or call UMP customer service: Toll Free: 1-800-762-6004    Seattle: 425-670-3000</li><li>• <b>Elsewhere in U.S.:</b> -- <a href="http://www.beechstreet.com">www.beechstreet.com</a> or 1-800-937-2277.</li></ul>
<hr/>
Send medical claims to: (Electronic Payer ID: 75243) Uniform Medical Plan P.O. Box 34850, Seattle WA 98124-1850
<hr/>
Prescription drugs can be purchased at participating retail pharmacies or through our delivery by mail service. For more information contact Express Scripts at 1-866-576-3862 or <a href="http://www.express-scripts.com">www.express-scripts.com</a> .

## 1.3

### Claims Submission Information

Paper claims (UB-92) should be mailed within 60 days of service (but not beyond 365 days) to the UMP claims office at the following address:

**Uniform Medical Plan**  
**P.O. Box 34850**  
**Seattle, WA 98124-1850**

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission provides efficiency to your business.

If you are already connected to one of the following clearinghouses that frequently transmits claims electronically, continue to submit your UMP claims to payer I.D. number 75243.

**Electronic Network Systems**  
**www.enshealth.com**  
Toll-free ..... 1-800-341-6141

**Emdeon Business Services™**  
*(formerly known as WebMD)*  
**www.emdeon.com**  
Toll-free ..... 1-877-469-3263

**MedAvant Healthcare Solutions**  
*(formerly known as ProxyMed)*  
**www.proxymed.com**  
Toll-free ..... 1-800-586-6870

**The SSI Group**  
**www.thessigroup.com**  
Toll-free ..... 1-800-880-3032

If you are currently submitting paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically.

## 1.4

### Provider Network Participation

UMP PPO benefits are structured to encourage enrollees to use the services of network providers. As a financial incentive and to promote quality of care, the plan provides for considerable cost sharing for enrollees who do not use network providers.

As a UMP network provider, you are expected to refer patients to other network providers. Contact UMP at 1-800-464-0967 or 425-686-1246 when you need to confirm a provider's participation in the network. If the patient is a UMP Neighborhood enrollee, see Appendix A-3 for referral information and pass requirements.

UMP recognizes that most providers have established referral patterns and we do not wish to disrupt them. If the providers you routinely refer to are not UMP PPO network providers, but are interested in joining the UMP PPO network, please refer them to the Provider Services Division by calling toll-free 1-800-292-8092, or locally 206-521-2023. Non-network providers will also be solicited at your request. Please note, however, that all providers must meet UMP credentialing criteria prior to receiving network provider status.

UMP PPO is not a closed network. However, due to administrative resource constraints, we have established priorities for adding new providers. UMP is focusing on the credentialing of applicants in specialties and geographic areas where additions to the UMP PPO network are critical for enrollee access to care. When a request or application is received from a provider for a non-priority area, the provider is notified that we will not be processing the application at this time. Applicant information is retained for future consideration. UMP routinely analyzes statewide network adequacy in relation to the location and needs of our enrollees.

## 1.5

### UMP Web Site and Online Services

There is a dedicated section for providers on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) where up-to-date information can be easily obtained at any time. This includes the most current UMP *Certificates of Coverage* (benefit books), billing manuals, fee schedules, *Preferred Drug List*, and the online provider directory.

Along with other health care organizations in the community, UMP uses a single portal (through OneHealthPort) for provider access to secure information. This secure provider portal can be accessed through the UMP Web site. This security measure allows UMP to link to providers' offices with important information needed to manage their UMP business such as:

- Benefits information on UMP PPO and UMP Neighborhood;
- Eligibility effective dates and basic demographics for UMP enrollees;
- Coordination of benefits information to determine if another insurance carrier, including Medicare, is primary for a patient;
- Deductible status as to whether the patient has met his/her deductible;
- Detailed claims information including message codes to let you know if a UMP PPO or UMP Neighborhood claim is in process, if more information is needed, or if a claim has been finalized;
- References and forms for billing, *UMP Neighborhood Pass* (applies only to UMP Neighborhood), a sample I.D. card, and filing claims electronically;
- Search capability for finding information in UMP's provider directory and *Preferred Drug List*;
- Secure e-mail to exchange messages containing confidential information with UMP's claims administrator.

To use the secure provider portal, click on "Online Services" or "OneHealthPort" in the provider section of the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov). You will need to choose an administrator from your organization to manage the organization's account and complete the OneHealthPort registration process, which you can do online. After registration, the administrator will have access to the UMP secure site and information. The designated administrator can then give appropriate staff in the organization their OneHealthPort credentials to access UMP information.

## 1.6

### Administrative Simplification Initiatives

Administrative simplification—reducing the hassle factor, streamlining policies and procedures, and decreasing nonproductive work—continues to be a key focus of UMP.

UMP has established an internal review process to identify and resolve burdensome administrative policies and procedures. UMP continues to work with other state agencies to develop, implement, and maintain uniform payment methodologies and policies that are consistent with industry standards.

UMP also participates with the Washington Health-care Forum in their administrative simplification initiatives. The Forum is a coalition of health plans, physicians, hospitals, and purchasers working together to standardize processes among payers. UMP has adopted many of the Forum's policies and guidelines related to claims processing, and referral and prospective reviews. These standard policies and guidelines are posted on the Forum's Web site at [www.wahealthcareforum.org](http://www.wahealthcareforum.org).

## Section 2

# Program Outline

**Questions regarding development of reimbursement rates and policies?  
Call 206-521-2023 or 1-800-292-8092.**

## 2.1

### Overview of the Uniform Medical Plan Preferred Provider Organization (UMP PPO)

The Uniform Medical Plan Preferred Provider Organization (UMP PPO) is a self-insured, preferred provider plan for public employees and retirees. It is sponsored by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA).

UMP PPO coverage includes medical, surgical, and obstetric services; chemical dependency and mental health treatment; organ transplants; and prescription drugs. All enrollees have benefits for routine preventive care, vision and hearing examinations, tobacco cessation services, and diabetic education. UMP follows the preventive care guidelines established by the U.S. Preventive Services Task Force when determining coverage for preventive care.

See the UMP *Certificates of Coverage* (available on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) or by calling 1-800-464-0967) for deductible, coinsurance, and co-payment requirements, as well as for a complete description of plan benefits and scope of coverage.

## 2.2

### Hospital Reimbursement

Payment rates are stipulated in the contract between the hospital and UMP. Inpatient claims are paid using the rates in effect on the date of discharge. Outpatient claims are paid using the date of service.

For inpatient hospital claims, all features of UMP's benefit design are applied based on the admission date of the patient. This includes, for example, determination of covered services, deductibles, copayments, and provider status (e.g., network or non-network). If the provider network provider status ends while an enrollee is hospitalized, payment is based on the contractual arrangement in effect at time of admission.

### 2.2.1 Inpatient Reimbursement for Acute Care Hospitals (Excluding Low-Volume, Critical Access, and Children's Hospitals)

The primary basis for UMP inpatient hospital payment is the All-Patient Diagnosis Related Group (AP-DRG) per-case system.

The reimbursement for AP-DRG claims is determined by multiplying the applicable AP-DRG relative weight by the hospital-specific conversion factor. For outlier information, refer to Section 7.5 of this manual.

#### **AP-DRG Relative Weight:**

Each AP-DRG is assigned a weight that measures the relative cost of treating patients in that AP-DRG compared to the cost of treating the average patient.

**Conversion Factor:** The conversion factor is a dollar amount, specific to each hospital. The conversion factor is developed from an initial base rate that represents statewide average operating costs per case. The initial base rate is adjusted on a hospital-specific basis that recognizes capital expenditures, area wage differences,

direct and indirect teaching costs, increased resources required to treat low-income patients, margin, uncompensated care, and inflation.

Exceptions to AP-DRG pricing include the hospitals identified in Section 2.2.2., specialized providers (such as cancer research centers), and the following categories of cases:

- Organ transplants (except cornea) covered by UMP, which are reimbursed at a hospital-specific percentage of charge rate;
- Psychiatric, chemical dependency, and rehabilitation AP-DRGs, which are reimbursed on a hospital-specific per diem basis;
- Low-volume AP-DRGs;
- Patients discharged/transferred to another distinct unit of the same hospital;
- Patients who leave against medical advice; and
- Patients discharged alive on the same day of admission (except normal delivery and normal newborn patients), which are reimbursed at a hospital-specific percentage of charge rate.

## **2.2.2 Inpatient Reimbursement for Low-Volume, Critical Access, and Children's Hospitals**

UMP has defined a set of low-volume, critical access, and children's hospitals for which per-case reimbursement is not applicable. These hospitals are reimbursed based upon a medical or surgical per diem rate. The reimbursement is determined by multiplying the applicable per diem rate (medical or surgical) by the length of stay for the case. The applicable per diem rate is determined by classifying a case into an AP-DRG, each of which has been defined as either medical or surgical.

## **2.2.3 Outpatient Reimbursement**

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Depending on the type of service and provider type, reimbursement for hospital outpatient facility charges is generally based on the:

- Medicare Ambulatory Payment Classification (APC) methodology;
- Percentage of allowed charges; or
- Rates on the *UMP Professional Provider Fee Schedule*.

Please refer to the payment addendum of your *Network Provider Agreement for Hospitals* for more information.

**APC Relative Weights:** The UMP weights are the same as those used by Medicare.

**Conversion Factor:** The conversion factor is a dollar amount specific to each hospital.

Hospitals excluded from the APC reimbursement methodology are:

- Children's hospitals
- Critical access hospitals
- Military and veteran's hospitals
- Out-of-state hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Rural hospitals
- Low-volume rural hospitals

## Section 3

# Billing Instructions

Questions regarding billing procedures? Call 206-521-2023 or 1-800-292-8092.

### 3.1

## Claim Submission Procedures

Questions regarding claims submission? Call 425-686-1246 or 1-800-464-0967.

### 3.1.1 Claim Submission Process

Claims submitted on paper must be mailed to UMP at:

**Uniform Medical Plan  
(or UMP Neighborhood)  
P.O. Box 34850  
Seattle, WA 98124-1850**

Incomplete claims will cause delay or denial of payment. Services submitted with invalid diagnosis or procedure codes will be denied.

You are encouraged to submit claims electronically. See Section 1.3, Claims Submission Information, to find out more about this option.

UMP does not require itemized billing statements with the submission of the UB-92 form on a routine basis. However, UMP reserves the right to request additional information before, during, and after the payment of the claim.

### 3.1.2 Timely Submission of Claims

Claims for covered services provided to an enrollee should be submitted within 60 days of the date of service. UMP will not pay claims submitted more than 12 months after the date of service. Under exceptional circumstances, such as when UMP is secondary and the primary payer has not paid on a timely basis, this provision may be waived upon approval by UMP.

To request a waiver, send a written memorandum explaining the circumstances to:

**Manager, Customer Service  
Uniform Medical Plan  
(or UMP Neighborhood)  
P.O. Box 34850  
Seattle, WA 98124-1850**

### 3.1.3 Interim Claims Policy

For inpatient admissions, interim claims are not accepted by UMP. UB-92 claim forms with a “30” in Form locator 22 (Patient Status) and/or a “2,” “3,” or “4” entered in Form locator 4 (Type of Bill), 3<sup>rd</sup> digit, will be returned to the hospital. Only “admit through discharge” claims (“1” in Form locator 4, UB-92, 3<sup>rd</sup> digit) are accepted for payment consideration.

Under exceptional circumstances of hardship, a hospital may appeal on a case-specific basis to UMP for a waiver of this policy. To appeal for a waiver, contact:

**Manager, Customer Service  
Uniform Medical Plan (or  
UMP Neighborhood)  
P.O. Box 34850  
Seattle, WA 98124-1850**

### 3.1.4 Process for Resubmission of Claims and Adjustments

**Corrected claims:** Providers are encouraged to attach the cover sheet found in Appendix A-6 of this manual when submitting corrected claims to UMP. This standard cover sheet is also posted on UMP’s Web site and the Washington Healthcare Forum’s Web site.

To resubmit a claim that was previously returned or denied for correction or additional information, simply attach a copy of the letter or Detail of Remittance (DOR) from UMP to the corrected claim or information requested, and send it back to UMP.

Please use the applicable code (“5,” “7,” or “8”) as the 3<sup>rd</sup> digit in Form locator 4 (Type of Bill) of the UB-92 when resubmitting a claim.

Corrected or resubmitted claims must be submitted on paper.

To request a reconsideration of a previously paid claim, network providers should contact UMP by phone or write to:

**Uniform Medical Plan (or  
UMP Neighborhood)  
P.O. Box 34578  
Seattle, WA 98124-1578**

Toll-free ..... 1-800-464-0967  
Local..... 425-686-1246

If UMP agrees that the claim warrants adjustment, you may be required to submit the corrected claim with supporting documentation and reason that the claim should be adjusted. Your request must be made no more than 180 calendar days after receiving the notice of action on the original claim.

The decision related to whether or not an adjustment is appropriate will generally be made within 30 calendar days of receiving the request for review. You will receive notice of the decision in the form of a new DOR with additional payment or a letter from UMP. If the adjustment is denied, you may submit a request for further reconsideration (or “Level 2 request”) through the process described in Section 8.1.3 of this manual.

**Note:** UMP expects providers to bill accurately for services rendered. Changing of procedure or diagnosis codes or modifying records for the sole purpose of gaining

additional payment from UMP, and not just to correct an error, is an indication of billing fraud.

### **3.1.5 Enrollee Appeals Procedure for Denied Claims**

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If a UMP enrollee feels that a claim has been incorrectly processed or payment wrongly denied, it is the responsibility of the enrollee to contact UMP at 1-800-762-6004. If the problem is not resolved to the satisfaction of the enrollee, he or she may appeal to:

**Uniform Medical Plan (or  
UMP Neighborhood)  
P.O. Box 34578  
Seattle, WA 98124-1578**

Details of this process can be found in the current *Certificates of Coverage*.

### **3.1.6 Audit and Right of Recovery Policy**

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UMP’s right to audit, inspect, and duplicate records maintained on enrollees by network providers is discussed in the contract between HCA/UMP and the provider.

Providers should promptly notify UMP of any overpayments or underpayments. UMP’s right to seek prompt refund from the provider for any duplicate, excess, or otherwise erroneous payments,

or to deduct the amount overpaid from future payments and take such action as it may consider appropriate, is also discussed in the contract between HCA/UMP and the provider.

### **3.1.7 Patients’ Rights to Confidentiality**

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It is the responsibility of the provider to keep audit, billing, payment, medical, and other patient-related information for UMP enrollees confidential, except as necessary for performance of the contract between HCA/UMP and the provider, unless required by law to do otherwise. The Notice of Privacy Practices is located on the UMP Web site and a hard copy is available on request.

3.1.8
Coordination of
Benefits (COB)

Please note that Mutual of Omaha electronically transmits Medicare claims information for Medicare-enrolled UMP enrollees directly to UMP for secondary payment. This includes Medicare claims processed by Noridian Administrative Services and other Medicare contractors. Therefore, it is generally not necessary for you or your patients to send UMP paper claims and copies of the Explanation of Medicare Benefits/Medicare Summary Notices.

For all other claims where UMP is the secondary payer, a copy of the original claim form along with a

copy of the EOB and/or Detail of Remittance (DOR) provided by the primary payer must be submitted to UMP for secondary payment.

When UMP PPO is secondary to another group medical insurance plan, reimbursement for services is based on standard coordination of benefits. This means that, after the enrollee’s annual deductible has been met, UMP PPO plus the enrollee’s other coverage combined pay up to 100 percent of allowed charges (but not more than 100 percent). Usually, enrollees who have UMP PPO as their secondary coverage pay no enrollee cost-share on most claims unless the annual deductible has not been satisfied.

For other services, here’s how it works when UMP PPO is not the primary payer:

- The primary payer pays a portion of the bill and sends the enrollee an Explanation of Benefits (EOB); the enrollee sends a copy of the bill and the EOB to UMP PPO;
- UMP PPO reviews the primary plan benefit calculation, and the primary plan payment;
- UMP PPO determines what the normal benefit would have been if UMP PPO had been the only payer;
- UMP PPO compares allowed charges and determines which is the highest allowed charge; and
- UMP PPO pays the difference between the highest allowed charge and the primary plan’s payment, up to the normal UMP PPO benefit amount.

Example of UMP Secondary Payment

Provider’s charge	\$1,200	
Primary Plan Benefit Calculation		
Primary plan’s allowed charge:	\$1,000	(contractual agreement)
Primary plan deductible (enrollee pays):	\$500	
Primary plan pays:	\$400	(80% of \$500 balance)
Patient responsibility:	\$600	
UMP PPO Benefit Calculation		
UMP allowed charge:	\$1,100	
UMP PPO deductible (enrollee pays):	\$200	
UMP PPO normal benefit:	\$810	(90% of \$900 balance)
UMP PPO pays:	\$600	(lesser of \$600 or \$810)

### **3.1.9**

#### **Explanation of Benefits (EOB)**

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When the claim is paid, the patient receives an Explanation of Benefits (EOB) that shows the original submitted charges, any noncovered charges, the patient's responsibility, and the amount paid by UMP.

The patient's EOB will also indicate when portions of the submitted charge have not been covered because the amount charged exceeds the contracted allowance for the service. The patient is not responsible for these charges and may not be billed for them.

### **3.1.10**

#### **Detail of Remittance (DOR)**

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Providers will receive a Detail of Remittance (DOR) from UMP, which will indicate the amount of charges being reimbursed for each claim. See the appendices of this manual for samples of DORs for

inpatient and outpatient facility charges for both UMP PPO and UMP Neighborhood. The DOR identifies the patient by name, identification number, and the claim number assigned by the claims administrator. Then, for each service line of the claim, the DOR lists the service date, the revenue/procedure code of the service, submitted charges, allowed amount, noncovered charges, message code(s), deductible/co-pay/coinsurance amounts (patient responsibility), network provider discounted amount, patient balance, and amount paid by UMP.

For quicker communications, providers may choose to receive DORs electronically from UMP through selected clearinghouses. Through this payment option, your organization doesn't have to wait for delivery of the paper DOR, which is mailed through the United States Postal Service. For more information, please contact UMP toll free at 1-800-464-0967 or locally at 425-686-1246.

### **3.1.11**

#### **Electronic Funds Transfer**

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Electronic Funds Transfer (EFT) is available to network providers. Through this function, UMP payments for claims are deposited more quickly and automatically into your organization's bank account. If you are interested in receiving your payments from UMP through this process, please send UMP a secure e-mail through your UMP provider portal account (set up via [www.onehealthport.com](http://www.onehealthport.com)). Once connected to the portal, click on the Electronic Funds Transfer links and follow the easy instructions on how to send a secure e-mail. There is no charge for this service.

## 3.2

### Instructions for Completing the UB-92 Claim Form

Hospital facility charges must be submitted on the UB-92 claim form or the electronic equivalent for payment consideration. See Exhibit 3-1 for a sample of the form. For reference, the form locator descriptions are included in the following table. Form locators shown in bold type signify important information. If information is missing or inaccurate, claims processing may be delayed or denied.

<b>UB-92 Form locator</b>	<b>Description</b>
<b>01</b>	<b>Provider Name, Address, Telephone Number</b>
02	Unlabeled Form locators
<b>03</b>	<b>Patient Control Number</b>
<b>04</b>	<b>Bill Type</b>
<b>05</b>	<b>Federal Tax Identification Number for Provider</b>
<b>06</b>	<b>Statement Covered Days</b>
07	Covered Days
08	Noncovered Days
09	Coinsurance Days
10	Lifetime Reserve Days
11	Unlabeled Form locator
<b>12</b>	<b>Patient's Name</b>
<b>13</b>	<b>Patient's Address</b>
<b>14</b>	<b>Patient's Birthdate</b>
<b>15</b>	<b>Patient's Sex</b>
<b>16</b>	<b>Patient Marital Status</b>
<b>17</b>	<b>Admission Date</b>
<b>18</b>	<b>Admission Hour</b>
19	Type of Admission/Visit
20	Source of Admission
21	Discharge Hour
<b>22</b>	<b>Patient Status</b>
<b>23</b>	<b>Medical/Health Record of Patient-Facility</b>
<b>24-30</b>	<b>Condition Codes</b>
32-35	Occurrence Codes
36	Occurrence Span Codes
37-39	ICN/DCN Codes
39-41	Value Codes
<b>42</b>	<b>Revenue Codes</b>
<b>43</b>	<b>Revenue Description</b>
<b>44</b>	<b>HCPC Rates and Modifiers</b>
<b>45</b>	<b>Service Dates</b>

<b>UB-92</b>	
<b>Form locator</b>	<b>Description</b>
<b>46</b>	<b>Service Units</b>
<b>47</b>	<b>Total Charges (By Revenue Code)</b>
<b>48</b>	<b>Non-Covered Charges</b>
<b>50</b>	<b>Payer Identification</b>
<b>51</b>	<b>Provider Number</b>
<b>52</b>	<b>Release of Information</b>
53	Assignment of Benefits
<b>54</b>	<b>Prior Payments From Other Payor Sources (i.e., Coordination of Benefits)</b>
<b>55</b>	<b>Estimated Amount Due From Current Payor</b>
<b>58</b>	<b>Insured Name</b>
<b>59</b>	<b>Patient's Relationship</b>
<b>60</b>	<b>Cert-SSN-HIC-ID No.</b>
<b>61</b>	<b>Insurance Group Name</b>
<b>62</b>	<b>Insurance Group Number</b>
<b>63</b>	<b>Treatment Authorization Code</b>
<b>64</b>	<b>Employment Status Code</b>
<b>65</b>	<b>Employer Name</b>
66	Employer Location
<b>67</b>	<b>Principal Diagnosis Code</b>
<b>68-75</b>	<b>Other Diagnosis Codes</b>
<b>76</b>	<b>Admitting Diagnosis Code</b>
<b>77</b>	<b>External Cause of Injury Code</b>
<b>79</b>	<b>Procedure Coding Method Used</b>
<b>80</b>	<b>Principal Procedure Code and Date</b>
<b>81</b>	<b>Other Procedures</b>
<b>82</b>	<b>Attending Physician ID</b>
83	Other Physician ID
84	Remarks
<b>85</b>	<b>Provider Rep Signature</b>
86	Date Bill Submitted

**Note:** The CMS-1500 form is the form most commonly used for billing professional services. Instructions for completing the CMS-1500 form are included in the *UMP Billing and Administrative Manual for Professional Providers*.

## Exhibit 3-1 Sample UB-92 Form

✓ Indicates a required field; see Section 3.2 for list.

ST 11643 1 PLY UB-92

APPROVED OMB NO. 0938-0279

1		2		3 PATIENT CONTROL NO.		4 TYPE OF BILL	
5 FED TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 COV D		8 INCD	
9 C/D		10 L/R D		11			
12 PATIENT NAME				13 PATIENT ADDRESS			
14 BIRTH DATE		15 SEX		16 MS		17 DATE	
18 HR		19 TYPE		20 SMO		21 D HR	
22 STAT		23 MEDICAL RECORD NO.		24		25	
26		27		28		29	
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890		891					

## 3.3

### Coding Information

UMP recognizes UB-92 claims data elements as defined by the National Uniform Billing Committee (NUBC). Standard UB-92 revenue codes are required on all service lines of a claim.

The most current versions of the ICD-9-CM diagnosis and procedure codes or CPT®/HCPCS codes are required for billing purposes. The diagnosis and procedure codes are added and revised by Medicare and the American Medical Association. The updated codes should be used for UMP claims, beginning at the same time that the codes become valid for use with Medicare claims.

All diagnosis and procedure codes on the claim form will be edited for validity and accuracy using the Medicare Inpatient Code Editor or Outpatient Code Editor, as applicable. Services submitted with invalid procedure or diagnoses codes will be denied. Incomplete claims will cause delay or denial of claims payment.

For inpatient cases that are not reimbursed on an AP-DRG per-case or per diem basis, a semi-private room rate is used to determine allowed charges. UMP may pay for private rooms (revenue codes 111–119 and 141–149) when determined to be medically necessary.

### 3.3.1

#### Revenue Code Billing Instructions for Outpatient Claims

The following revenue codes are accepted on outpatient facility claims without a corresponding CPT® code or HCPCS code. When billed by a facility reimbursed under the Outpatient Prospective Payment System (OPPS) APC methodology, these services are packaged services for which no separate payment is made. However, the cost of these services is included in determining outlier payments.

Revenue Code	Description
250	Pharmacy - General Classification
251	Pharmacy - Generic Drugs
252	Pharmacy - Non-Generic Drugs
253	Pharmacy - Take-Home Drugs
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
257	Non-Prescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy - General Classification
262	IV Therapy/Pharmacy Services
263	IV Therapy/Drugs/Supply Delivery
264	IV Therapy/Supplies
269	Other IV Therapy
270	Medical - Surgical Supplies
271	Non-Sterile Supply
272	Sterile Supply
274	Prosthetic/Orthotic Devices
275	Pacemaker
276	Intraocular Lens
277	Oxygen - Take Home
278	Other Implants
279	Other Supplies/Devices
280	Oncology - General Classification
289	Other Oncology
290	Durable Medical Equipment
343	Diagnostic Radiopharms
344	Therapeutic Radiopharms

<b>Revenue Code</b>	<b>Description</b>
370	Anesthesia - General Classification
371	Anesthesia - Incident to Radiology
372	Anesthesia - Incident to Other Diagnostic Services
379	Other Anesthesia
390	Blood - General Classification
399	Other Blood Storage and Processing
560	Medical Social Services - General Classification
569	Medical Social Services - Other Medical Social Services
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
624	Investigational Device (DE)
630	Drugs Requiring Specific Identification, General Class
631	Single Source
632	Multiple
633	Restrictive Prescription
681	Trauma Response Level I
682	Trauma Response Level II
683	Trauma Response Level III
684	Trauma Response Level IV
689	Trauma Response Other
700	Cast Room - General Classification
709	Other Cast Room
710	Recovery Room - General Classification
719	Other Recovery Room
720	Labor Room/Delivery - General Classification
721	Labor
762	Observation Room
810	Acquisition of Body Components
819	Other Donor

**For all other revenue codes not listed above, the applicable CPT® or HCPCS procedure code(s) must be included on a hospital outpatient facility claim.**

### 3.3.2 Type of Bill

Type of Bill (Form locator 4) is used to indicate the type of facility and bill classification (inpatient, outpatient, etc.) specific to a claim. This field is used by UMP in the claims adjudication process and is a required field.

### 3.3.3 Line Item Dates of Service

UMP requires line item dates of service to be reported on all outpatient hospital facility bills for each line where a CPT® or HCPCS procedure code is required. This includes claims where the “from” and “through” dates are the same. Omission of these dates will delay processing.

### 3.3.4 Service Units

UMP recognizes a service unit as the number of times a service or procedure was performed per the CPT®/HCPCS code definitions. Providers should not report multiple units on the claim form for any procedure code where it is not supported by these definitions.

### 3.3.5 Modifiers

UMP recognizes the following CPT® and HCPCS modifiers on the UB-92:

Modifier	Description
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
50	Bilateral Procedure
52	Reduced Services
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
59	Distinct Procedural Service
73	Discontinued Out-Patient Procedure Prior to Anesthesia Administration
74	Discontinued Out-Patient Procedure After Anesthesia Administration
76	Repeat Procedure by Same Physician
77	Repeat Procedure by Another Physician
78	Return to the Operating Room for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period
91	Repeat Clinical Diagnostic Laboratory Test
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit

Modifier	Description
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
LC	Left circumflex, coronary artery
LD	Left anterior descending coronary artery
RC	Right coronary artery
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

### 3.3.6 Repetitive Services

UMP expects providers to follow Medicare billing guidelines for repetitive services.

### 3.3.7 Outpatient Code Editor (OCE) Edits

UMP generally follows Medicare guidelines and applicable versions of the Outpatient Code Editor (OCE), which are generally updated quarterly. UMP recognizes that some Medicare inpatient-only procedures may be appropriate in an outpatient setting. Hospitals will be reimbursed for those services according to the payment addendum of your *Network Provider Agreement for Hospitals*.

## 3.4

### Outpatient Observation Billing Policy

Hospitals billing for observation should follow Medicare billing policy. UMP follows Medicare coverage criteria when determining whether observation services are eligible for separate APC reimbursement. Observation services eligible for separate reimbursement are calculated using a single unit.

## Section 4

# Provider Information

### 4.1

## Provider Requirements

Uniform Medical Plan network providers agree to comply with the following requirements.

### 4.1.1 Credentialing

**Call 206-521-2023 or 1-800-292-8092**

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by HCA/UMP.
- Meet all other credentialing requirements documented in your *Network Provider Agreement* as determined by HCA/UMP.
- Accept UMP fee schedules and follow UMP policies and procedures.

### 4.1.2 Billing

**Call 425-686-1246 or 1-800-464-0967**

- Bill UMP your usual and customary fee.
- Submit claims on the UB-92 form for hospital or skilled nursing facility inpatient or outpatient claims within 60 days

after the covered services are rendered. Professional services should be billed on the CMS-1500 forms, except where Medicare allows these services to be included on the UB-92 claim form. Claims will not be paid more than 12 months after the date of service, except as noted in Section 3.1.2.

- Ensure that enrollees are not billed for any amounts above the maximum allowed charge.
- The enrollee responsibility cannot always be determined at the time of the visit. Therefore, UMP prefers that providers collect applicable deductibles and coinsurance amounts from UMP enrollees after receiving the detail of remittance documenting the enrollee responsibility.

### 4.1.3 Referrals and Authorizations

**Call 425-686-1246 or 1-800-464-0967**

- Refer enrollees to UMP network providers and network facilities, except where no appropriate network provider is available or in case of an emergency.
- An online provider directory of network providers by city and specialty is available on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov). In the directory, it is noted whether

the network provider is board certified and if they are not accepting new patients. Network home health and hospice agencies, including infusion therapy providers, are listed in the directory by counties served. Searching for network providers within a specified travel distance from an enrollee's home can be done with the links to driving directions and maps by MapQuest provided.

The online directory is updated twice a month. Non-network providers can apply for network status by contacting UMP. All providers must meet UMP selection criteria prior to receiving network provider status. Because the UMP's provider network continues to expand, it is important to verify a provider's network status by contacting UMP Customer Service at 425-686-1246 or 1-800-464-0967 prior to referring patients to that provider. If you notice that the information listed for you on our Web site is not accurate, please call Provider Services at 1-800-292-8092 or send updates via e-mail to [umpprovider@hca.wa.gov](mailto:umpprovider@hca.wa.gov).

- Call UMP to preauthorize the procedures identified in Section 6.1.3.
- Notify UMP of hospital stays exceeding 10 days, as well as for the hospital admission diagnoses listed in Section 6.1.2.

- See Section 6 of this manual for detailed information about UMP utilization review requirements. In addition, see the applicable *UMP Certificates of Coverage*, which list preauthorization requirements, covered benefits, exclusions, and limitations to benefits.

## Section 5

# Enrollee Responsibilities

**Patient questions regarding benefits, network provider status, claims payment? Call 1-800-762-6004 (active employees) or 1-800-352-3968 (retirees).**

### 5.1

## Enrollee Requirements

Enrollee education is an important factor in ensuring the timely and appropriate payment of health care benefits. UMP enrollees are instructed to follow these guidelines when obtaining health care services:

- Choose a provider from the *Network Provider Directory* as found on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov), or call UMP Customer Service.
- Verify that the services they are obtaining are covered by UMP by referring to their *UMP Certificates of Coverage*, or by calling UMP.
- Identify themselves as a UMP enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Remind their physician to refer them to UMP network providers and to admit them to UMP network hospitals.
- Promptly remit applicable deductibles, coinsurance, copayments, and/or payment for non-covered services.
- Obtain preauthorization from UMP for:
  - Cardiac and pulmonary rehabilitation.
  - Certain injectable drugs that are not normally approved for self-administration, when obtained through a retail pharmacy or UMP's mail-service pharmacy (these drugs are indicated on the *UMP Preferred Drug List*).
  - Cochlear implants.
  - Durable medical equipment, supplies, and prostheses for rentals beyond three months or purchases over \$1,000.
  - Genetic testing (except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed. Authorization may be granted only for testing performed by a specialist center/provider designated by UMP).
  - Home health care in which visits are daily or expected to exceed two hours a day, or when the length of treatment is expected to last more than three weeks. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
  - Hospice care (in order to be covered at the highest benefit level).
  - Inpatient admissions for rehabilitation (physical, occupational, and speech therapy).
  - Massage therapy in excess of one hour per treatment.
  - Mental health partial hospitalization services.
  - Negative pressure wound therapy pumps and related services.
  - Organ transplants: All organ transplants (including bone marrow, umbilical cord, and stem cell transplants). Patient must be accepted into the treating facility's transplant program and follow the program's protocol.
  - Positron emission tomography (PET) scans, except for diagnosis or staging of cancer.
  - Respite care.
  - Skilled nursing facility admissions.
  - Some prescription drugs (see the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) for an up-to-date list of drugs that require preauthorization).
  - Temporomandibular joint (TMJ) surgery.

In addition, some frequently prescribed durable medical equipment such as light boxes, hospital beds, and breast

pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.

**Please note:** For outpatient services, if the APC allowed charge is greater than the billed charge, the member's coinsurance will be based on the billed charge. UMP will reimburse the difference to the provider.

If your patients have questions regarding benefits, network provider status, or payment of claims, please refer them to UMP at the above-referenced numbers.

## Section 6

# Utilization Review

### Notification/preauthorization questions?

Call 425-686-1246 or 1-800-464-0967.

## 6.1

### Utilization Review Requirements

#### 6.1.1 Overview

UMP Medical Review professionals perform utilization and quality review, as well as case management services for our enrollees.

To notify UMP of hospital admissions, (see Section 6.1.2), preauthorize services (see Section 6.1.3), or determine eligibility, call the numbers at the beginning of this section.

UMP's utilization management program includes review of certain medical services before, during, and after they are delivered. Reviews are conducted for:

- Optional case management (selected complex or high-expense cases);
- Notifying UMP of certain diagnoses (see Section 6.1.2);
- Required case management; and
- Retrospective (postpayment) review.

The purpose of the review is to determine whether or not services are medically necessary and

delivered in the most appropriate setting. Such reviews help to:

- Monitor quality of care;
- Ensure that treatment is necessary and consistent with good medical practices;
- Discourage unnecessary care;
- Save health care dollars; and
- Identify chronic and catastrophic cases appropriate for case management.

#### 6.1.2 Notification of Hospital Admissions

The purpose of this program is to allow UMP the earliest possible identification of patients for whom case management services may be appropriate. Please notify UMP about patients with complex medical conditions like:

- Cancer
- Chemical dependency
- Chronic respiratory disease
- Congenital defects
- Congenital heart disease
- CVA (cerebrovascular accident/stroke)
- Diabetes
- HIV disease
- Ischemic heart disease/peripheral vascular disease
- Neonatal complications
- Neurodegenerative disorders (multiple sclerosis, amyotrophic lateral sclerosis, muscular dystrophy)

- Organ transplant, including stem cell and bone marrow
- Pregnancy (complications of)
- Spinal cord injury
- Trauma (multiple trauma, head injury)
- Any hospital stay exceeding 10 days

The medical condition of the enrollee will be evaluated to determine if case management is indicated. Notification is not necessary when Medicare or another plan requiring prior notification/preauthorization is the primary payer.

**Note:** The notification process does not involve approval for medical necessity or preauthorization of services. These admissions may be subject to retrospective (postpayment) review.

#### 6.1.3 Preauthorization

To ensure that standard benefits are received by the enrollee, prior authorization by the plan must be received before you render the following services:

- Cardiac and pulmonary rehabilitation.
- Certain injectable drugs that are not normally approved for self-administration, when obtained through a retail pharmacy or

UMP's mail-service pharmacy (these drugs are indicated on the *UMP Preferred Drug List*).

- Cochlear implants.
- Durable medical equipment, supplies, and prostheses for rentals beyond three months or purchases over \$1,000.
- Genetic testing except when associated with pregnancy or when associated with treatment decisions for a condition already diagnosed. Authorization may be granted only for testing performed by a specialist center/provider designated by UMP).
- Home health care in which visits are daily or expected to exceed two hours a day, or when the length of treatment is expected to last more than three weeks. Reauthorization is required every two weeks unless determined otherwise by Medical Review. (Please call 1-888-759-4855 prior to the start of home health services in these cases.)
- Hospice care (in order to be covered at the highest level of benefit).
- Inpatient admissions for rehabilitation (physical, occupational, and speech therapy).
- Massage therapy in excess of one hour per treatment.
- Mental health partial hospitalization services.
- Negative pressure wound therapy pumps and related services.
- Organ transplants: All organ transplants (including bone marrow, umbilical cord, and stem cell transplants). Patient must be accepted into the treating facility's transplant program and

follow the program's protocol.

- Positron emission tomography (PET) scans, except for diagnosis or staging of cancer.
- Respite care.
- Skilled nursing facility admissions.
- Some prescription drugs (see the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) for an up-to-date list of drugs that require preauthorization).
- Temporomandibular joint (TMJ) surgery.

In addition, some frequently prescribed durable medical equipment such as light boxes, hospital beds, and breast pumps, are covered only when they have been determined to be medically necessary. It may be to your patient's benefit to request preauthorization on these items.

See the *UMP Certificates of Coverage* for specific information on preauthorization requirements and scope of coverage of these benefits.

### **6.1.4 Requirements for Skilled Nursing Facilities (SNF)– Medicare-Approved Only**

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Medical review is required for skilled nursing facility admissions prior to payment. To request preauthorization, call UMP at the numbers at the beginning of this section.

Medical review is not required when Medicare or another plan that requires preauthorization is the primary payer and is providing

benefits. If Medicare or another plan is denying coverage, or Medicare limits have been exceeded, medical review will be required by UMP.

At the time of medical review or preauthorization, all cases will be screened for referral to Case Management.

## **6.1.5 Case Management**

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### **6.1.5.1 Optional Case Management**

Case management is a collaborative process that may include a UMP nurse case manager coordinating with hospitals, skilled nursing facilities, or other facilities by telephone or on-site visits. This will require the cooperation of the facility and the attending physician.

Generally, cases are identified as candidates for case management through the notification process. However, a facility or provider may suggest other patients with chronic or catastrophic illnesses for referral to case management. In this instance, the facility or provider should call 1-888-759-4855 to speak to a nurse case manager (see Section 6.1.2).

### **6.1.5.2 Required Case Management**

The UMP Medical Director or his/her delegate may review an enrollee's medical records and evaluate whether the enrollee's

use of medical services is unsafe, potentially harmful, excessive, or medically inappropriate. Based on this review, UMP may require an enrollee to participate in and comply with a case management plan as a condition of continued payment for services under UMP.

Among other services, case management often includes designating a primary provider to coordinate care, and designating a single hospital and pharmacy to provide covered services or medications. UMP has the right to deny payment for any services received outside the required case management plan with the exception of medically necessary emergency services provided outside the service area.

## **6.1.6 Retrospective Review**

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Certain admissions and services may be subject to retrospective (postpayment) review. This process involves an assessment of the:

- Medical necessity of the admission and/or procedure(s) performed;
- Appropriateness of the treatment setting or length of treatment;
- Patient's status upon discharge;
- AP-DRG validation;
- General quality of care delivered; and
- Validation of the procedure(s) and diagnoses codes submitted.

Providers and facilities are responsible for supplying any requested medical records or documentation

required to complete these reviews. Failure to comply with such requests may result in denial of benefits.

## **6.1.7 Review Criteria and Quality Screens**

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UMP professional staff use multiple resources, including Medicare coverage criteria, payment policies, and manuals; and other national guidelines when conducting case reviews. In the majority of cases, UMP follows Medicare coverage and billing guidelines. If the nurse determines that a case does not meet the review criteria, the case will be referred to the UMP Medical Director. The decision to approve or deny is made by the UMP Medical Director after consultation with the attending physician, when appropriate, and is based on medical experience and expertise.

## Section 7

# Payment Policies

Questions? Call 425-686-1246 or 1-800-464-0967.

## 7.1

### General Information

#### 7.1.1

#### ***UMP PPO Certificate of Coverage***

The *UMP PPO Certificate of Coverage* (COC) (available on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) or by calling 1-800-762-6004) is the official source of plan benefits and scope of coverage information. Throughout this section of the billing manual, key information from the COC that is pertinent to the benefit under discussion may be referenced for the provider's information. **Providers must rely on the COC to obtain full and complete information regarding the scope of coverage and benefit provisions.** Refer to the "How the UMP PPO Works" section of the COC for a listing of provider types approved to deliver services.

#### **7.1.2 Plan Payment Provisions for Providers**

Unless otherwise specified in this manual or the COC, the enrollee's applicable calendar year deductible must be satisfied before the plan will make a payment for services provided under a given benefit.

Services exempt from the annual medical/surgical deductible include:

- Preventive care\*;
- Retail and mail-order prescription drugs\*\*;
- Routine vision exams and hardware;
- Required second surgical opinions; and
- Tobacco cessation services provided through the *Free & Clear* smoking cessation program.

*\*UMP follows the preventive care guidelines established by the U.S. Preventive Services Task Force (USPSTF) when determining coverage for preventive care.*

*\*\*UMP PPO has a separate annual deductible for prescription drugs. It is a combined retail and mail-order deductible. See the UMP PPO Certificate of Coverage for more details.*

In the *UMP PPO Certificate of Coverage* and elsewhere, "non-network" and "out-of-network" refer to services from providers who are not contracted with UMP, Beech Street, or American WholeHealth Networks. "Non-network" is usually used to refer to situations where the enrollee had the opportunity to use a network provider but chose not to. "Out-of-network" refers to situations where the enrollee did not have access to a network provider, as determined by UMP. After the enrollee's annual medical/surgical deductible has been met, inpatient facility charges are subject to an enrollee copayment. In 2006, the copayment amount is \$200 per day, capped at a maximum of \$600 per year. For outpatient facility, professional, and all other services, the plan's payment provisions generally are as follows:

- For **network providers**, the plan pays 90 percent of the allowed charge. (The "allowed charge" is the provider's billed charge or the applicable contracted fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.
- For **non-network providers**, UMP pays 60 percent of the allowed charge. However, when the enrollee does not have access to a network provider, the

plan pays at the out-of-network rate (80 percent of the allowed charge). (The “allowed charge” is the provider’s billed charge or the fee schedule amount in Washington, whichever is less. In all other states, the allowed charge is based on a regionally adjusted charge.) The enrollee is responsible for the coinsurance (40 percent or 20 percent), as well as any outstanding balance above UMP’s allowed charge. Refer to the *UMP PPO Certificate of Coverage* for specific details regarding the payment provisions, plan benefits, and scope of coverage.

These payment provisions are in effect until the enrollee’s annual medical/surgical out-of-pocket limit or benefit limit is reached. However, services paid at the non-network provider rate do not count towards the enrollee’s annual medical/surgical out-of-pocket limit, and are exempt from that limit.

The payment provisions described above are in effect until the enrollee’s lifetime maximum benefit limit is reached.

For additional details regarding payment provisions, plan benefits, and scope of coverage, see the *UMP PPO Certificate of Coverage*.

**Note:** *UMP enrollees also have access to network providers in most other parts of the United States through the Beech Street network (see directory at [www.beechstreet.com](http://www.beechstreet.com)). Within Washington and the four Idaho border counties of Bonner, Kootenai,*

*Latah, and Nez Perce, Beech Street providers are not considered UMP network providers unless they also contract directly with UMP.*

**Also note:** Services rendered under private contracts by providers who “opt out” of the Medicare program will not be covered or reimbursed by UMP. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and preventive care services/procedures, which will be processed and paid according to UMP benefits. In a private contract situation, the UMP enrollee is solely responsible for the provider’s total billed charges.

### 7.1.3 Patient’s Financial Responsibility

Network providers agree to accept the UMP allowed amount as full compensation for covered services, and agree not to bill enrollees for any amounts above the contracted allowed amount.

Except as provided below or in your network provider agreement, the patient can be billed for:

- Any applicable deductible, co-payment, or coinsurance;
- Any charges for services specifically excluded in the applicable *UMP Certificate of Coverage*; or
- Any charges for services that exceed benefit limits, in the case of benefits with specific visit, day, or dollar limits.

The patient **cannot** be billed for:

- Any amounts above the UMP allowed amount;
- Any supplies or procedures that are included (“bundled/packaged”) in the UMP allowed amounts for other services;
- Any amounts for which UMP is responsible; or
- Any services that UMP determines are not or were not medically necessary, including services determined by UMP to be experimental or investigational. An exception to this requirement is made if the patient understood, prior to receiving the service, that the specific service would not be covered by UMP, and agreed in writing to assume financial responsibility for the service.

The enrollee cost-sharing responsibility cannot always be determined at the time of the visit. Therefore, UMP prefers that providers collect applicable deductibles, copayments, and coinsurance amounts from UMP enrollees after receiving the detail of remittance documenting the enrollee responsibility.

## 7.2

### Hospital Inpatient Stay Definition

An inpatient stay is defined as a Uniform Medical Plan (UMP) enrollee who has been admitted to the hospital, incurs room and

board services, and is expected to remain 24 hours or longer.

The AP-DRG payment amount includes all pre-admission, diagnostic, appliance, pharmaceutical, operative, treatment, and room and board charges for the patient, for the period beginning one calendar day prior to the date of admission and extending through date of discharge.

If the hospital has an ambulatory surgery program or a “day patient” program where an enrollee receives services which require a hospital stay of less than 24 hours, services must be billed as outpatient.

## 7.3

### Non-Covered Revenue Codes

Charges for the following services should be listed as noncovered (Form locator 48); they will generally not be considered for payment.

Revenue Code	Description
180–189	Leave of Absence
220 <sup>1</sup>	Special Charges
256	Experimental Drugs
257	Pharmacy - Non-Prescription
399	Other Blood Storage and Processing
670	Outpatient Special Residence Charges
723	Newborn Circumcision
819	Other Donor
941	Recreational Therapy
942 <sup>2</sup>	Education/Training (see exception below regarding Diabetes Education)
949	Other Rx Svcs/Weight Loss
960–989 <sup>3</sup>	Professional Fees
990–999	Patient Convenience Items

<sup>1</sup> Revenue code 220 (Special Charges) requires submittal of additional information identifying and justifying the charges.

<sup>2</sup> For revenue code 942 (Education/Training), UMP does provide benefits for Medicare-approved diabetes education programs and follows Medicare protocol and criteria.

<sup>3</sup> Revenue Codes 960 through 989 (Professional Fees) are generally not covered when billed on a UB-92 form. These services should be billed separately with the appropriate CPT®/HCPCS code on a CMS-1500 form or electronic equivalent. The charges for these services are not bundled into the facility reimbursement and will be considered separately if submitted on a CMS-1500 form. Covered professional charges will be paid using the UMP Professional Provider Fee Schedule.

## 7.4

### Services Prior to Admission

For cases paid on an AP-DRG per-case basis, all services provided within one calendar day prior to admission will be considered part of the admission and covered by the AP-DRG reimbursement rate. This includes, but is not limited to, radiology, pathology, and emergency room services. Any charges for services on the calendar day prior to admission must be submitted on the inpatient UB-92 bill and not billed separately as an outpatient service. The Statement Covers Period (Form locator 06 on the UB-92) should reflect the admission date (from) and discharge date (through).

## 7.5

### Cost Outliers: Inpatient Claims Paid Using AP-DRGs

Outlier claims are those claims with unusually high or low costs. Catastrophic losses for which a hospital may be at risk are the major focus of UMP's outlier policy.

**High Cost Outliers:** UMP's high cost outlier payment methodology applies to cases where the costs exceed a specific outlier threshold, as defined in the payment addendum of your hospital contract. If a case meets the definition of a high cost outlier, the following equation is used in determining the reimbursement amount:

$$\text{Reimbursement amount} = \text{Inlier Amount} + [ (\text{percentage of Charges} \times \text{Allowed Charges}) - \text{Threshold} ]$$

#### Definitions

*Inlier Amount*—the allowed amount for the specific AP-DRG which the claim is grouped to.

*Percentage of Charges*—defined in the payment addendum of the hospital contract.

*Allowed Charges*—billed charges minus any charges for non-covered revenue codes identified in Section 7.3 of this billing manual.

*Threshold*—the dollar amount or percentage of inlier amount (whichever is greater) specified in the payment addendum of the hospital contract.

**Low Charge Outliers:** UMP's low charge outlier payment methodology applies to cases where the allowed charges are: (a) less than the low charge outlier threshold for the AP-DRG (indicated in the applicable AP-DRG weight file on the UMP Web site) or (b) 5 percent of the inlier amount; whichever is greater. In these situations, the claims are reimbursed at the contracted percentage of allowed charges.

## 7.6

### Late Claims and Relationship to High-Cost Outlier: Inpatient Claims

Late claims are defined as those claims that contain charges submitted by the hospital to UMP after submission of the final claim. These claims are identified by a "5" entered in Form locator 4 (Type of Bill), 3<sup>rd</sup> digit, of the UB-92 form.

For claims paid on an AP-DRG or per diem basis, all charges on late claims will be denied and the hospital notified with a message indicating that the case has been paid in full under the AP-DRG or per diem payment system.

In the case of claims paid on an AP-DRG per-case basis, it is possible that the allowable charges on a late claim could be sufficiently great to qualify the case for high-cost outlier reimbursement. If a hospital believes that this situation has occurred, **it is the hospital's responsibility to notify UMP**, and request a review of the claim for possible readjudication. Such review will not occur automatically when late claims are received.

Submit written appeals for high-cost outliers to:  
**Manager, Customer Service**  
**Uniform Medical Plan (or UMP Neighborhood)**  
**P.O. Box 34578**  
**Seattle, WA 98124-1578**

## 7.7

### Transfers: Inpatient Claims

**Network Hospital Paid Under AP-DRG Methodology:** A transfer of a patient to another hospital is reimbursed based on the AP-DRG payment amount or the hospital's contracted percentage of allowed charges, whichever is less. These cases are commonly referred to as transfer-out cases, and are defined on the UB-92 by a code of "02" entered in Form locator 22 (Patient Status).

**Exceptions** to the above payment policy are for AP-DRG 456 (Burn Transfer), and AP-DRGs 639 and 640 (Neonate Transfers). These AP-DRGs are reimbursed the AP-DRG payment amount or as low-volume AP-DRGs, whichever is appropriate. Low-volume AP-DRGs are defined in the hospital contract with UMP and are reimbursed the contracted percentage of allowed charges. All transfer-out cases should be coded "02" in Form locator 22 (Patient Status).

Discharges/transfers to subacute care within the network hospital are reimbursed the lesser of the AP-DRG payment amount or the hospital's contracted percentage of allowed charges. The acute care portion of the stay will be reimbursed according to the reimbursement methodologies outlined in Section 2 of this manual.

There is no special reimbursement arrangement for the receiving (also known as the transfer-in) hospital.

**Per Diem-Based Network Providers:** Transfer cases (into or out of the hospital) are reimbursed at the applicable medical or surgical per diem rate.

## 7.8

### Readmissions: Inpatient Claims

Inpatient cases in which a readmission for the same or a similar condition occurs within 30 days of a previous discharge may be reviewed by UMP on a retrospective basis.

## 7.9

### Identification of Transplant Cases: Inpatient Claims

Subject to preauthorization, those cases that group as transplant AP-DRGs and all other organ transplants (except cornea) covered by UMP are paid at the contracted rate.

## 7.10

### Discounting Rules for Multiple Surgical Procedures: Outpatient Claims

UMP applies Medicare's payment policy when processing multiple surgical procedures provided during the same operative session.

The APC-based payments in these multiple surgical procedure situations are as follows:

- Procedure with the highest weight value is priced based on 100 percent of the APC payment; and
- Subsequent procedures are priced at 50 percent.

## 7.11

### Terminated Procedures: Outpatient Claims

Surgical procedures terminated prior to the induction of anesthesia will be paid at 50% of the APC-based allowed amount.

## 7.12

### **AP-DRG and APC Grouping of Claims**

UMP will assign the inpatient claim to an All-Patient Diagnosis Related Group (AP-DRG) during claims processing. The grouping and pricing methodology used is based on patient discharge date. Outpatient hospital claims reimbursed under the Outpatient Prospective Payment System (OPPS) will be grouped to the appropriate APC based on service date. Hospitals are not required to group claims prior to submission.

## Section 8

# Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions

**Please note:** The section below applies specifically to provider concerns. There is a separate appeals process for enrollees seeking a change in UMP coverage or benefit determinations. Complaints and appeals on behalf of enrollees should be addressed under that process, which is described in detail in the UMP Certificates of Coverage.

**Questions? Call 425-686-1246 or 1-800-464-0967.**

## 8.1

### Provider Inquiry, Complaint, Reconsideration Procedures, and Dispute Resolutions

UMP has specific procedures for provider inquiries, complaints, and claim reconsideration requests. Definitions for each of these and the procedures follow.

#### 8.1.1 Inquiry

A request for information or for an explanation.

If you have an inquiry such as a question on claims payment status, plan benefits, or enrollee eligibility, please call UMP Provider Services at 425-686-1246 or 1-800-464-0967. In most cases, your question will be answered right away.

#### 8.1.2 Complaint

An expression of dissatisfaction submitted on behalf of a provider regarding:

- Coverage or payment for health care services; or
- UMP policies or practices.

To register a complaint, you may also contact UMP Provider Services at the above numbers; fax the complaint to 425-670-3197; or write to:

**Uniform Medical Plan  
(or UMP Neighborhood)  
P.O. Box 34578  
Seattle, WA 98124-1578**

Most complaints will be resolved immediately or within one business day of receipt. However, for more complex issues, the turn-around time for reviewing and responding to provider complaints may be up to 30 calendar days.

#### 8.1.3 Reconsideration

Reevaluation of a previous decision by UMP in response to a provider's

written request. The request may be in reference to:

- An adverse decision regarding a complaint;
- An unresolved claims processing issue;
- Decision to deny, modify, reduce, or terminate payment, coverage, or preauthorization for health care services or benefits. (Note that issues raised specifically on behalf of an enrollee or at the direction of an enrollee follow a separate appeals process described in the UMP *Certificates of Coverage*, and are not considered provider reconsiderations.)

Issues specifically relating to provider contract provisions, credentialing criteria for network participation, and approved provider types are also handled through a process that is separate from provider reconsideration requests (see Section 8.2).

There are two levels of provider reconsiderations:

**Level I:** Within 180 days of receiving the notice of action lead-

ing to the request, submit your request for reconsideration to:

**Uniform Medical Plan  
(or UMP Neighborhood)  
First-Level Provider  
Reconsideration  
P.O. Box 34578  
Seattle, WA 98124-1578**

Please include the date of service and indicate clearly the issues that you wish to be reconsidered. Your request will be assigned to the appropriate experienced UMP staff, depending on the issue.

Most requests are completed within 30 calendar days of the date UMP received your request for reconsideration. If the decision is to reprocess the claim, you will receive a Detail of Remittance as notification. Otherwise, you will receive a written response.

**Level 2:** If you do not agree with the decision at Level 1 of the reconsideration process, you may submit a request for further reconsideration to:

**Uniform Medical Plan  
(or UMP Neighborhood)  
Provider Relations Committee  
Second-Level Provider  
Reconsideration  
P.O. Box 34578  
Seattle, WA 98124-1578**

Requests for Level 2 reviews must be submitted within 60 calendar days of the date of the Level 1 determination. Include all of the information that was reviewed through the Level 1 reconsideration process, a copy of the Level 1 determination, and any other information or documentation you think may be helpful. Your request for a Level 2 reconsideration will be

reviewed by our Provider Relations Committee. Most decisions will be made within 30 calendar days from receipt of your request for reconsideration.

**Please note:** There are no further reconsideration processes available through UMP for non-network providers. The Level 2 reconsideration process is the final decision of UMP.

If you are a network provider and are not satisfied with the outcome of the second level determination, you may request a dispute hearing with the Administrator of the Health Care Authority (HCA), using the dispute resolution procedure described below.

## **8.1.4 Dispute Resolution**

A network provider may request a dispute hearing with the Administrator of the HCA. Instead of handling the issue personally, the Administrator of the HCA may designate someone to act on his or her behalf, following the same procedures and with the same effect as described below.

These dispute resolution procedures are not offered to non-network providers. Also, they do not apply to issues raised on behalf of enrollees (see the current UMP *Certificates of Coverage* for enrollee appeals procedures). Disputes will be resolved as quickly as possible.

A. The request for a dispute hearing must:

- Be in writing and signed by either the provider requesting the hearing or the provider's representative;
- State the disputed issue(s);
- State the provider's position on the issues;
- Confirm that all other contractually available procedures for resolving the issue have been exhausted;
- Include the name and address of the provider, as well as the name of any person acting on the provider's behalf in the matter of the hearing; and
- Be mailed within 30 days of the date of the letter with UMP's second-level decision to:

**Uniform Medical Plan  
(or UMP Neighborhood)  
Provider Dispute Hearing  
Request  
P.O. Box 91118  
Seattle, WA 98111-9218**

- B. The UMP Director of Operations may provide a written statement setting forth UMP's position and reasoning, and including any information that may be helpful. Any statement by UMP on the dispute must be mailed to the Administrator and the provider within 20 working days after receipt of the provider's statement.
- C. The Administrator shall review the written statements and reply in writing to the provider and UMP Director of

Operations within 30 working days. The Administrator may extend this period by notifying all parties.

Both UMP and the provider will continue without delay to carry out all their respective responsibilities as defined by contract.

## 8.2

### **Provider Contract or Network Issues**

Inquiries, complaints, or disputes concerning provider contract provisions should be directed to:

**Uniform Medical Plan  
(or UMP Neighborhood)  
Hospital Reimbursement  
Specialist  
P.O. Box 91118  
Seattle, WA 98111-9218**

# Appendices

- A-1 UMP PPO Detail of Remittance (DOR), Inpatient (example)
- A-2 UMP PPO Detail of Remittance (DOR), Outpatient (example)
- A-3 UMP Neighborhood Information (including an example of the *UMP Neighborhood Pass* [referral form])
- A-4 UMP Neighborhood Detail of Remittance (DOR), Inpatient (example)
- A-5 UMP Neighborhood Detail of Remittance (DOR), Outpatient (example)
- A-6 Cover Sheet for Corrected Claims
- A-7 Adds/Terms/Changes (ATC) Submission Process

Appendix A-1 UMP PPO Detail of Remittance (DOR), Inpatient (example)

UNIFORM MEDICAL PLAN  
PO BOX 34850  
SEATTLE WA 98124-1850  
Toll Free: 1-800-762-6004

HOSPITAL  
PO BOX 99999  
SEATTLE WA 98124

SEE LAST PAGE FOR  
EXPLANATION OF CODE

PROV#: 11111111  
TAX #: 11111111  
DATE: 04/01/2006  
DRAFT#: 00257980  
ENVOY/REC ID#: 75243

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/ROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY CONS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST MEMBER 999999999														
W999999999 G99999998-00														
			03/02/06		0	9,561.00	5,522.78	.00	PPU	.00	600.00	4,038.22	.00	4,922.78
			03/02/06	120	3	3,576.00			*RG					
			03/02/06	250	82	2,584.00			*RG					
			03/02/06	300	2	92.00			*RG					
			03/02/06	301	5	195.00			*RG					
			03/02/06	305	2	152.00			*RG					
			03/02/06	306	6	804.00			*RG					
			03/02/06	307	1	55.00			*RG					
			03/02/06	320	2	504.00			*RG					
			03/02/06	410	6	406.00			*RG					
			03/02/06	450	1	1,058.00			*RG					
			03/02/06	460	1	69.00			*RG					
			03/02/06	710	2	66.00			*RG					
		APDRG	374		CLAIM TOTAL	9,561.00	5,522.78	.00			.00	4,038.22	.00	
													Payment	4,922.78
													TOTAL PAID 4,922.78	

Code Descriptions

\*\*\*\*\*  
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.  
\*\*\*\*\*  
PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.  
\*RG TOTAL DRG ALLOWABLE IS ON THE FIRST LINE. CLAIMS > 17 LINES ARE SEGMENTED. ADD FIRST LINE OF EACH SEGMENT FOR TOTAL DRG.  
\*\*\* REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO: UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98125-1578



UNIFORM MEDICAL PLAN  
PO BOX 34850  
SEATTLE WA 98124-1850  
TollFree:1-800-762-6004

HOSPITAL  
PO BOX 999999  
SEATTLE WA 98124

PROV#: 11111111  
TAX #: 11111111  
DATE: 04/04/2006  
Draft#: 00297980  
ENVOY REC ID#: 75243

SEE LAST PAGE FOR  
EXPLANATION OF CODE

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY CONS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID	
TEST MEMBER 999999999	W999999999 J99999999-00	00034	03/02/06	450	99282	1	166.00	223.51	.00	Z9	16.60	.00	91.60	131.91	
		00000	03/02/06	300	87184	1	166.00	145.00	.00	PPU	14.50	21.00	14.50	130.50	
		00000	03/02/06	320	73092	1	166.00	145.00	.00	PPU	14.50	21.00	14.50	130.50	
	APDRG			CLAIM TOTAL		498.00	513.51	.00		75.00	45.60	42.00	120.60	392.91	
														Payment	392.91
														TOTAL PAID	392.91

Code Descriptions

\*\*\*\*\*  
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.  
\*\*\*\*\*  
PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE  
FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.  
Z9 THIS AMOUNT INCLUDES ALL OR PART OF THE PATIENTS EMERGENCY ROOM VISIT COPAY. THE EMERGENCY ROOM COPAY IS \$75.00 FOR EACH VISIT.  
\*\*\* REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED TO INCLUDE BUNDLING COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO UNIFORM MEDICAL PLAN P.O. BOX 34578, SEATTLE WA 98125-1578



P0002166  
ENV 3471  
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# **UMP Neighborhood**

Administered by the Uniform Medical Plan

## **Appendix A-3**

### **UMP Neighborhood Information**

This supplement provides information and instructions for the UMP Neighborhood Care Systems and other providers outside of the Care Systems who may also treat UMP Neighborhood enrollees. Billing and claims submission procedures for services to UMP Neighborhood enrollees are the same whether or not the provider is affiliated with the enrollee's Care System. However, the enrollee's cost-sharing is higher for most services outside their Care System, with some exceptions.

## **Section I**

# **Quick Reference Notes**

## **1.1**

### **How to Reach Us**

Find UMP Neighborhood information on  
the UMP Web site:  
[www.ump.hca.wa.gov](http://www.ump.hca.wa.gov)

#### **1.1.1**

### **Addresses and Phone Numbers**

#### **UMP Neighborhood Customer and Provider Services**

- Benefits information
- Claims status and information
- Enrollee eligibility information\*
- General billing questions
- Interactive Voice Response (IVR) system
- Medical review
- Notification/preauthorization
- Referral process
- Verify provider's Care System or network status

#### **\*Automated Enrollee Eligibility Information**

Toll-free 1-800-335-1062 (Have subscriber I.D. number available, and select #2 for "PEBB subscriber information.")

#### **UMP Neighborhood**

P.O. Box 34850

Seattle, WA 98124-1850

#### **Provider Services**

Toll-free ..... 1-800-464-0967

Local..... 425-686-1246

Fax ..... 425-670-3199

#### **Enrollees**

Toll-free ..... 1-888-380-2822

#### **Case Management Services**

Toll-free ..... 1-888-759-4855

#### **Electronic Claims Submission**

The following clearinghouses frequently submit claims electronically to UMP.

#### **Electronic Network Systems**

[www.enshealth.com](http://www.enshealth.com)

Toll-free ..... 1-800-341-6141

#### **Emdeon Business Services™**

(formerly known as WebMD)

[www.emdeon.com](http://www.emdeon.com)

Toll-free ..... 1-877-469-3263

#### **MedAvant Healthcare Solutions**

(formerly known as ProxyMed)

[www.proxymed.com](http://www.proxymed.com)

Toll-free ..... 1-800-586-6870

#### **The SSI Group**

[www.thessigroup.com](http://www.thessigroup.com)

Toll-free ..... 1-800-880-3032

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## **Provider Credentialing and Contracting Issues**

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- Billing manuals and payment policies
- Change of provider status
- Fee schedules
- Network provider applications and contract information
- New provider enrollment
- Policies and procedures
- *Provider Bulletin* feedback

### **Uniform Medical Plan**

**P.O. Box 91118**

**Seattle, WA 98111-9218**

Toll-free ..... 1-800-292-8092

Local..... 206-521-2023

Fax ..... 206-521-2001

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## **Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians Network**

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- Network provider applications and contract information
- Billing procedures
- Fee schedule and payment policy information

### **American WholeHealth Networks**

(Axia Health Management; formerly Alternäre)

Toll-free ..... 1-800-500-0997

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## **Prescription Drugs (retail and mail-order)**

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- Benefits information
- Claims information
- Cost share information
- Eligibility verification
- Preferred drug list information
- Prior authorization requests
- Network pharmacy information (location and network verification)

### **Express Scripts, Inc.**

Toll-free ..... 1-800-763-5502

### **To fax prescriptions (providers)**

Toll-free ..... 1-800-396-2171

*Must be faxed on provider's letterhead*

### **To call in prescriptions (providers)**

Toll-free ..... 1-800-763-5502

### **Preauthorization of prescription drugs**

Toll-free ..... 1-800-417-8164

Fax ..... 1-877-697-7192

### **Appeals and Correspondence**

Toll-free ..... 1-800-417-8164

Fax ..... 1-877-852-4070

### **Express Scripts, Inc.**

**Attn: Pharmacy Appeals: WA5**

**Mail Route BLO390**

**6625 West 78th Street**

**Bloomington, MN 55439**

### **Vendor for Specialty Prescription Drugs**

#### **CuraScript**

To call in prescriptions for specialty drugs

Toll-free ..... 1-866-413-4135

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## **Tobacco Cessation Services**

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### **Free & Clear**

Toll-free ..... 1-800-292-2336

## 1.1.2

### Web Site Information

#### UMP Neighborhood

[www.ump.hca.wa.gov](http://www.ump.hca.wa.gov)

- *Billing & Administrative* manuals (includes billing and payment policy information for UMP Neighborhood)
- *Certificate of Coverage* (benefits book)
- *Network Provider Directory*
- *Preferred Drug List*
- *Professional Provider Fee Schedule*
- *Ambulatory Surgery Center Fee Schedule*
- *Anesthesia Fee Schedule*
- *Chiropractor Fee Schedule*
- *Prosthetic and Orthotic Fee Schedule, Including Ostomy and Urological Supplies*
- All-Patient Diagnostic Related Group Weights used for Hospital Inpatient Reimbursement
- Other important UMP Neighborhood information

#### OneHealthPort

[www.onehealthport.com](http://www.onehealthport.com)

- Register with OneHealthPort for access to secure online services and e-mail to manage your UMP Neighborhood business

#### U.S. Preventive Services Task Force Guidelines

[www.ahcpr.gov/clinic/gpspsu.htm](http://www.ahcpr.gov/clinic/gpspsu.htm)

- Preventive care guidelines

#### Centers for Disease Control's National Immunization Program

[www.cdc.gov/nip/publications/ACIP-list.htm](http://www.cdc.gov/nip/publications/ACIP-list.htm)

#### Express Scripts, Inc.

[www.express-scripts.com](http://www.express-scripts.com)

- General prescription drug information

**Note:** See the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) for UMP-specific information on prescription drugs.

#### Free & Clear

[www.freeclear.com](http://www.freeclear.com)

- Tobacco cessation program information

#### American WholeHealth Networks

(Axia Health Management; formerly Alternäre)

[www.wholehealthpro.com](http://www.wholehealthpro.com)

- Licensed Acupuncturists, Licensed Massage Practitioners, and Naturopathic Physicians—network provider resources information

## 1.2

### Sample UMP Neighborhood Identification Card

This is the identification card that confirms UMP Neighborhood enrollment. **Please note:** The card also identifies the applicable Care System selected by the enrollee. Except as explained in Section 4.1.3 of this appendix, UMP Neighborhood enrollees receive the highest (network) level of reimbursement only when they use providers affiliated with the Care System they selected.

This card does not guarantee coverage. To confirm eligibility or obtain benefit information and requirements for prior approval, contact the plan at 1-888-380-2822 or 425-670-3018. To find a provider or get benefit information, you can also go to [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov).

FAX UMP NEIGHBORHOOD REFERRALS TO: 425-670-3197

Send medical claims to Electronic Payer ID: 75243  
or by mail to: UMP Neighborhood  
PO Box 34850  
Seattle, WA 98124-1850

Prescription drugs can be purchased at participating retail pharmacies or through our delivery by mail service. For more information, contact Express Scripts at 1-866-576-3862 or [www.express-scripts.com](http://www.express-scripts.com).

  
**UMP Neighborhood**  
Administered by the Uniform Medical Plan

Enrollee Name:  
Subscriber ID No:  
Care System:

 EXPRESS SCRIPTS

RxBin: 003858

RxPCN: A4

Rx Group: WA5A

You must present this card when you use a Care System provider, UMP referral provider, and at participating pharmacies for direct claim filing and the most cost effective services.

## 1.3

### Claims Submission Information

Paper claims should be mailed within 60 days of service (but not beyond 365 days) to the UMP Neighborhood claims office at the following address:

**UMP Neighborhood**  
**P.O. Box 34850**  
**Seattle, WA 98124-1850**

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission provides efficiency to your business.

If you are already connected to one of the following clearinghouses that frequently transmits claims electronically, submit your UMP Neighborhood claims to payer I.D. number 75243.

**Electronic Network System**  
**[www.enshealth.com](http://www.enshealth.com)**  
Toll-free ..... 1-800-341-6141

**Emdeon Business Services™**  
(formerly known as WebMD)  
**[www.emdeon.com](http://www.emdeon.com)**  
Toll-free ..... 1-877-469-3263

**MedAvant Healthcare Solutions**  
(formerly known as ProxyMed)  
**[www.proxymed.com](http://www.proxymed.com)**  
Toll-free ..... 1-800-586-6870

**The SSI Group**  
**[www.thessigroup.com](http://www.thessigroup.com)**  
Toll-free ..... 1-800-880-3032

If you are currently submitting paper claims, we encourage you to contact a clearinghouse for information on submitting claims electronically.

## 1.4

### Provider Network Participation

UMP Neighborhood benefits are structured to encourage enrollees to use the services of providers affiliated with the Care System they have selected. As a financial incentive and to promote quality of care, the plan applies considerable cost sharing for enrollees who self-refer to providers who are not in their Care System or on their Care System's panel of referral specialists. There are exceptions for certain provider types (see Section 4.1.3 of this appendix).

Care System providers are expected to refer patients to other providers within their Care System or to specialists who are on their Care System's panel. When it is necessary to refer a UMP Neighborhood patient to a provider who is not affiliated with the patient's Care System, referrals should be to a UMP PPO network provider for services to be reimbursed at the network benefit level. See Section 4.1.3 of this appendix for instructions on notifying our claims administrator of referrals outside the patient's Care System.

The UMP Neighborhood online directory (updated twice a month) is available on the Web site at **[www.umpndirectory.net](http://www.umpndirectory.net)**. You can also view UMP PPO's online provider directory and network pharmacy directory on the UMP Web site at **[www.ump.hca.wa.gov](http://www.ump.hca.wa.gov)**. A

provider's participation status can also be confirmed by calling UMP Neighborhood at 1-888-380-2822 or 425-686-1218. For referral to a Uniform Medical Plan PPO provider, call 1-800-464-0967 or 425-686-1246.

## 1.5

### UMP Web Site and Online Services

Refer to Section 1.5 of this manual for information on the UMP Web site and online services that is also applicable to UMP Neighborhood.

## 1.6

### Administrative Simplification Initiatives

Refer to Section 1.6 of this manual for information on administrative simplification initiatives that is also applicable to UMP Neighborhood.

## Section 2

# Program Outline

### 2.1

## Overview of UMP Neighborhood

UMP Neighborhood, which is administered by the Uniform Medical Plan (UMP), provides coverage to enrollees in King, Snohomish, and Pierce counties. UMP Neighborhood enrollees have the same benefits as those enrolled in UMP's traditional preferred provider organization (PPO), but they receive care from a more limited choice of network providers. As of January 1, 2006, health care services provided to UMP Neighborhood enrollees are no longer subject to a medical/surgical deductible. The annual prescription drug deductible still applies to UMP Neighborhood enrollees. The plan's goals include offering incentives to both providers and enrollees to make cost-effective health care decisions, and providing more affordable plan choices for PEBB members.

UMP Neighborhood is built upon organized "systems of care" consisting of primary care providers, and a panel of specialists and facilities chosen by the Care System. Primary care providers can participate in only one Care System. Specialists and hospitals may participate in multiple Care Systems.

There are currently 12 UMP Neighborhood Care Systems participating. They are identified with their Care System code on the Web site at [www.ump.hca.wa.gov/nhood/](http://www.ump.hca.wa.gov/nhood/) and in the *UMP Neighborhood Provider Directory*. The directory also includes information provided by each of the Care Systems about their program.

Refer to the *UMP Neighborhood Certificate of Coverage (COC)* for deductible (prescription drug), co-insurance, and copayment requirements, as well as for a complete description of plan benefits and scope of coverage. The COC is available on the UMP Web site at [www.ump.hca.wa.gov/nhood/](http://www.ump.hca.wa.gov/nhood/) or by calling 1-888-380-2822.

### 2.2

## Inpatient Hospital Reimbursement

Refer to Section 2.2 of this manual for inpatient hospital facility reimbursement information that is also applicable to UMP Neighborhood.

### 2.3

## Outpatient Hospital Reimbursement

Refer to Section 2.2.3 of this manual for outpatient hospital reimbursement information that is also applicable to UMP Neighborhood.

## *Section 3*

# **Billing Instructions**

Refer to Section 3 of this billing manual for hospital facility billing information and instructions for completing the UB-92 claim form. Information pertaining to the explanation of benefits (EOB), and detail of remittance (DOR) notices is also available in this section.

See Appendices A-4 and A-5 for a sample of the UMP Neighborhood DORs for hospital inpatient and outpatient facility charges.

## Section 4

# Provider Information

### 4.1

## Provider Requirements

UMP Neighborhood Care System providers agree to comply with the following requirements.

### 4.1.1 Credentialing Information

- Maintain applicable licensure, registration, and/or certification.
- Maintain professional liability insurance coverage with limits of liability as determined by HCA/UMP.
- Meet all other UMP Neighborhood credentialing requirements.
- Submit provider updates following the UMP Adds/Terms/Changes (ATC) submission process provided in Appendix 7 of this manual.
- Accept UMP fee schedules and follow UMP policies and procedures.

### 4.1.2 Billing Information

Refer to Section 4.1.2 of this manual for billing information that is also applicable to UMP Neighborhood.

### 4.1.3 Referrals and Authorizations

UMP Neighborhood Care Systems are responsible for managing their panel of providers, including referral specialists. In most cases, UMP Neighborhood enrollees must use the providers in their selected Care System or its panel of referral specialists to obtain the maximum level of benefits. When referring a patient for care outside his or her Care System's panel, Care System providers should refer UMP Neighborhood enrollees to a provider within the UMP PPO network unless one is not available for the type of care needed. In addition, the Care System provider should issue a *UMP Neighborhood Pass* when referring the patient outside of his or her Care System's panel. The main purpose of the *UMP Neighborhood Pass* is to notify our claims administrator how to reimburse the claim. With the pass, covered services provided by UMP PPO network providers are paid at the network benefit level (usually 90 percent of allowed charges). Covered services provided by providers not in the UMP PPO network are paid at the out-of-network benefit level (usually 80 percent of allowed charges).

**Please note:** Care System providers do not need to notify our claims administrator of a referral to the following provider types.

Enrollees receive network-level benefits when self-referring to any UMP PPO network provider of the following types. Note below some limits on services when self-referring.

- Acupuncturists
- Alcohol/chemical dependency centers and substance abuse treatment facilities
- Ancillary facilities such as home health or hospice agencies, ambulatory surgery centers, and skilled nursing facilities
- Audiologists
- Behavioral health providers such as psychologists, psychiatrists, licensed mental health counselors, licensed social workers, licensed marriage and family counselors, and psychiatric nurses (ARNP)
- Chiropractors
- Community mental health agencies
- Durable medical equipment suppliers
- Hearing aid fitters and dispensers
- Massage therapists (must be a UMP PPO or American WholeHealth Network massage therapist, and services require a written treatment plan from a qualified clinician)
- Midwives
- Naturopathic physicians
- Optometrists (if outside care system, self-refer only for routine vision services)

- Ophthalmologists (if outside care system, self-refer only for routine vision services)
- Pharmacies/pharmacists
- Prosthetic and orthotic suppliers
- Skilled nursing facilities
- State mental hospitals
- Tobacco cessation program (*Free & Clear* is the only tobacco cessation program covered)

**The following hospital/facility-based physicians who may not be included in the patient's Care System but are necessary for the treatment of the patient will be considered as Care System providers if they are in the UMP PPO provider network:**

- Anesthesiologists
- Emergency room physicians
- Radiologists
- Hospitalists
- Pathologists

**Finally, the following facilities/suppliers are also considered Care System providers if they are in the UMP PPO provider network:**

- Free-standing radiology facilities (including physicians interpreting the x-rays)
- Independent lab facilities

**Ambulances and free-standing urgent care facilities will be covered at the out-of-network benefit level (usually 80 percent of allowed charges).**

A copy of the *UMP Neighborhood Pass* for referrals outside of the enrollee's Care System is included on the following page. The pass is also available online. The Care System should fax the completed pass to UMP Neighborhood at 425-670-3197, or complete it online and e-mail it through our secure Web site. In addition, the Care System should give a copy of the pass to the patient for the provider to whom they are referred.

#### **4.1.3.1 Self-Referral for Women's Health Care**

For covered women's health care services, UMP Neighborhood enrollees will receive network-level benefits when they self-refer to a UMP PPO provider (physician, physician assistant, midwife, or advanced registered nurse practitioner)—regardless of whether the provider is affiliated with their Care System. Women's health care services include:

- Maternity care, reproductive health services, and gynecological care;
- General examinations, preventive care, and medically appropriate follow-up visits for the services previously mentioned or other health services particular to women;

- Appropriate care for other health problems that are discovered and treated during a visit for covered women's health care services.

If a woman self-refers to a non-network provider within Washington State for women's health care services, covered services will be reimbursed at the non-network benefit level.

## UMP Neighborhood Pass

For \_\_\_\_\_

For Referrals Outside the Care System

**Please fax to UMP Neighborhood at 425-670-3197, or complete form online  
and e-mail through our secure Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov).**

**Note:** This form does not imply coverage of services not covered by UMP Neighborhood, or those requiring preauthorization. See the *UMP Neighborhood Certificate of Coverage* for details.

**Provider:** Please give the patient a copy of this form. **Patient:** Give your copy to the provider to whom you are referred.

---

### Patient and Subscriber Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

Patient Home Phone \_\_\_\_\_

---

### Provider To Whom Referral is Being Made Referred To

\_\_\_\_\_  
Provider (Last, First) \_\_\_\_\_ Type of Provider (such as M.D. or D.O.) \_\_\_\_\_

\_\_\_\_\_  
Street Address \_\_\_\_\_ Specialty \_\_\_\_\_

\_\_\_\_\_  
City/State/ZIP Code \_\_\_\_\_ Phone Number \_\_\_\_\_

---

### Reason for Referral and Referring Provider

Diagnosis \_\_\_\_\_ ICD-9 Code \_\_\_\_\_ Date of Referral \_\_\_\_\_

Reason for referral \_\_\_\_\_

Expected length of treatment \_\_\_\_\_

Referral requested for      Consultation      Consultation/Test/Treatment      All Services

### Referred By

\_\_\_\_\_  
Print Provider Name \_\_\_\_\_ Provider Address \_\_\_\_\_

\_\_\_\_\_  
Provider Signature \_\_\_\_\_ City/State/ZIP Code \_\_\_\_\_

\_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

## Section 5

# Enrollee Responsibilities

### 5.1

## Enrollee Requirements

UMP Neighborhood enrollees should seek all medical care through providers within the Care System as identified on their I.D. card, except for providers/facilities that they can self-refer to as previously indicated in Section 4.1.3 of this appendix. If they seek medical care outside of the Care System without a *UMP Neighborhood Pass* when required, payment for covered services will be at the UMP non-network benefit level (generally 60 percent of allowed charges).

Enrollee education is an important factor in ensuring the timely and appropriate payment of health care benefits. When seeking health care, UMP Neighborhood enrollees have the responsibility to:

- Use their UMP Neighborhood Care System and network providers when available to help ensure quality care at the lowest cost.
- Identify themselves as a UMP Neighborhood enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.

- Understand UMP Neighborhood benefits, including what is covered, preauthorization and review requirements, and other information described in the *UMP Neighborhood Certificate of Coverage*.

UMP Neighborhood enrollees may change to a different Care System during the plan year with at least 30 days' notice. If the new Care System is accepting new patients, coverage is effective the first of the month following the 30 days' notice. In these circumstances, UMP Neighborhood will issue a new I.D. card to the patient to reflect the change to a different Care System.

If your patients have questions regarding UMP Neighborhood benefits, network provider status, or payment of their claims, please refer them to:

### UMP Neighborhood Customer Service

Toll-free ..... 1-888-380-2822

Local.....425-686-1218

## *Section 6*

# **Utilization Review Requirements**

Refer to Section 6 of this billing manual for preauthorization and utilization review requirements, including review criteria and case management information that are also applicable to UMP Neighborhood. Care System providers are encouraged to contact case management on all catastrophic cases.

## Section 7

# Payment Policies

### 7.1

## General Information

### 7.1.1

#### ***UMP Neighborhood Certificate of Coverage***

The *UMP Neighborhood Certificate of Coverage* (COC) (available on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov) or by calling 1-888-380-2822) is the official source of plan benefits and scope of coverage information. Providers must rely on the COC to obtain full and complete information regarding the scope of coverage and benefit provisions of UMP Neighborhood.

### 7.1.2

#### **Plan Payment Provisions for Providers**

UMP Neighborhood enrollees are not subject to an annual medical/surgical deductible, which means the plan begins paying benefits for covered services with the first health care service. Enrollees are responsible for an annual prescription drug deductible. See the *UMP Neighborhood Certificate of Coverage* for more details.

The plan's payment provisions generally are as follows:

- For covered services from **providers affiliated with the enrollee's Care System, or from providers of the types listed in Section 4.1.3 of this appendix who are contracted with UMP PPO**, the plan pays 90 percent of the allowed charge. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.

- For covered services from **other providers**, the plan pays:
  - 90 percent of the allowed charge when a *UMP Neighborhood Pass* has been issued **and** the provider is a UMP PPO network provider. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 10 percent.
  - 80 percent of the allowed charge when a *UMP Neighborhood Pass* has been issued and the provider is not a UMP PPO network provider. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) The enrollee is responsible for the remaining 20 percent plus the difference between the allowed and billed charges.
  - 60 percent of the allowed charge when a *UMP Neighborhood Pass* has not been issued, regardless of whether the provider is a UMP PPO network provider or is participating as a UMP Neighborhood provider with a different Care System. (The "allowed charge" is the provider's billed charge or the fee schedule amount, whichever is less.) In this circumstance, the enrollee is responsible for the remaining 40 percent if the provider is a UMP PPO network provider. A UMP PPO network provider cannot bill the enrollee for the difference between the billed and allowed charge. If the provider is not a UMP PPO network provider, the enrollee is responsible for the remaining 40 percent plus any difference between the allowed and billed charges.

For all providers (Care System, UMP PPO, and non-network), UMP fee schedules and payment policies determine the allowed charges used for UMP Neighborhood reimbursement. These fee schedules and the UMP billing manual are available on the UMP Web site at [www.ump.hca.wa.gov](http://www.ump.hca.wa.gov). Note that a payment differential applies to certain categories of providers.

This differential is described in Section 7.1.3 of the *UMP Billing & Administrative Manual for Professional Providers*.

In referral situations where a *UMP Neighborhood Pass* is not required as indicated in Section 4.1.3 of this appendix, UMP Neighborhood payment is based on the network or non-network status of the provider and the applicable benefit.

Emergency care from non-network or out-of-area providers is based on 80 percent of allowed charges.

For details regarding benefits and scope of coverage for UMP Neighborhood enrollees, see the *UMP Neighborhood Certificate of Coverage*. As explained in that document, UMP Neighborhood enrollees have an annual medical/surgical out-of-pocket limit, as well as some benefit limits.

- When benefits are paid as network or “out-of-network” (generally used to refer to situations when the enrollee did not have access to network services, as determined by UMP), the enrollee’s coinsurance and copayments count towards his/her annual medical/surgical out-of-pocket limit.
- “Non-network” services (when the enrollee had access to network services but did not use them) are not counted towards the enrollee’s medical/surgical out-of-pocket limit.

Once the enrollee’s medical/surgical out-of-pocket limit is reached, most network and out-of-network services will be paid at 100 percent for the remainder of that calendar year. Specific benefit limits, however, still apply.

**Note:** Services rendered under private contracts by providers who “opt out” of the Medicare program will not be covered or reimbursed by UMP Neighborhood. Exceptions are services provided on an emergency/urgent basis or that are excluded under the Medicare program, such as routine eye exams and certain preventive care services/procedures, which will be processed and paid according to UMP Neighborhood benefits. In a private contract situation, the enrollee is solely responsible for the provider’s total billed charges.

### **7.1.3 Patient’s Financial Responsibility**

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Section 7.1.3 of this manual applies to UMP Neighborhood as well as UMP PPO.

## *Section 8:*

# **Provider Inquiries, Complaints, Reconsideration Procedures, and Dispute Resolutions**

Refer to Section 8 of this billing manual for procedures for inquiries, complaints, claims reconsideration requests, and dispute resolutions that are also applicable to UMP Neighborhood.

UMP NEIGHBORHOOD  
P O BOX 34850  
SEATTLE WA 98124-1850  
Toll Free: 1-800-762-6004

HOSPITAL  
PO BOX 999999  
SEATTLE WA 98124

PROV#: 11111111  
TAX#: 11111111  
DATE: 04/01/2006  
D ref#: 00297980  
ENVOY A/E/C ID#: 75243

SEE LAST PAGE FOR  
EXPLANATION OF CODE

PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/ROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY COMS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST MEMBER 999999999	W999999999 G9999998-00	APDRG	374	CLAIM TOTAL	9,561.00	5,522.78	.00	PPU	.00	600.00	4,038.22	.00	4,922.78	
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Code Descriptions

\*\*\*\*\*  
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.  
\*\*\*\*\*  
PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.  
\*RG TOTAL DRG ALLOWABLE IS ON THE FIRST LINE. CLAIMS > 17 LINES ARE SEGMENTED. ADD FIRST LINE OF EACH SEGMENT FOR TOTAL DRG.  
\*\*\* REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED TO INCLUDE BUNDLING, COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO: UNIFORM MEDICAL PLAN, P.O. BOX 34578, SEATTLE, WA 98125-1578



Appendix A-5 UMP Neighborhood Detail of Remittance (DOR), Outpatient (example)

UMP NEIGHBORHOOD PO BOX 34850 SEATTLE WA 98124-1850 TollFree:1-800-762-6004	HOSPITAL PO BOX 99999 SEATTLE WA 98124	SEE LAST PAGE FOR EXPLANATION OF CODE	PROV#:11111111 TAX#:11111111 DATE:04/04/2006 Dra#:#00297980 ENVOY NET ID#:75243
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PATIENT NAME ACCOUNT #	BENEFIT ID # CLAIM #	APC	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	ALLOWED AMOUNT	NONCOVD	CODE	DEDUCTIBLE AMOUNT	COPAY CONS	PPO DISCOUNT	PATIENT BALANCE	AMOUNT PAID
TEST MEMBER W999999999 J9999999-00														
		00034	03/02/06	450	99282	1	166.00	223.51	.00	Z9	16.60	.00	91.60	131.91
		00000	03/02/06	300	87184	1	166.00	145.00	.00	PPU	14.50	21.00	14.50	130.50
		00000	03/02/06	320	73092	1	166.00	145.00	.00	PPU	14.50	21.00	14.50	130.50
		APDRG		CLAIM TOTAL		498.00	513.51	.00		75.00	45.60	42.00	120.60	392.91
													Payment	392.91
													TOTAL PAID 392.91	

Code Descriptions

\*\*\*\*\*  
PLEASE NOTE: THE ATTACHED DRAFT MAY INCLUDE BENEFIT PAYMENTS FOR MORE THAN ONE OF YOUR PATIENTS. PLEASE REFER TO THIS DETAIL OF REMITTANCE LISTING TO ENSURE EACH OF YOUR PATIENTS IS CREDITED WITH THE CORRECT PAYMENT AMOUNT.  
\*\*\*\*\*  
PPU THIS IS YOUR PLANS PARTICIPATING PROVIDERS CONTRACTUAL ALLOWANCE  
FOR THIS SERVICE. PROVIDER AGREES TO REDUCE THE FEE TO THE AMOUNT ALLOWED.  
Z9 THIS AMOUNT INCLUDES ALL OR PART OF THE PATIENTS EMERGENCY ROOM VISIT COPAY. THE EMERGENCY ROOM COPAY IS \$75.00 FOR EACH VISIT.  
\*\*\* REQUESTS FOR RECONSIDERATION OF THE WAY A CLAIM WAS PROCESSED TO INCLUDE BUNDLING COB OR ALLOWABLE FEE ISSUES, SHOULD BE DIRECTED TO UNIFORM MEDICAL PLAN P.O. BOX 34578, SEATTLE WA 98125-1578



F0002166  
ENV 3471  
110717

## Corrected Claim—Standard Cover Sheet

Health Plan: \_\_\_\_\_ Product: \_\_\_\_\_

Attention: \_\_\_\_\_

Date Cover Sheet Prepared: \_\_\_\_\_

♦ This is NOT a DUPLICATE claim. Please forward to the appropriate area for reprocessing. ♦

**Be sure to attach the updated claim form!**

### Claim Identification Information:

Original Claim Number (from voucher): \_\_\_\_\_

### Provider Office Contact Person:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Other Information: \_\_\_\_\_

### This claim is a corrected billing of a previously processed claim for the following reason(s):

- |  |   |
|--|---|
| <input type="checkbox"/> Corrected diagnosis           | <input type="checkbox"/> Corrected procedure code (CPT or CM) |
| <input type="checkbox"/> Corrected date of service     | <input type="checkbox"/> Addition, or correction, of modifier |
| <input type="checkbox"/> Corrected charges             | <input type="checkbox"/> Corrected provider information       |
| <input type="checkbox"/> Corrected patient information |   |
| <input type="checkbox"/> Other: _____                  |   |

Any specific clarification/comment/instructions (e.g., the claim line that was corrected):

Supporting Documentation Attached? ☐ Yes ☐ No

**Privacy Statement:** This document contains confidential information. Any disclosure, copying or distribution is prohibited. If you have received this information in error, please notify the sender and destroy all copies.

## Appendix A-7

# Adds/Terms/Changes (ATC) Submission Process

**This section applies to both UMP PPO and UMP Neighborhood as described below.**

### I. Additions

#### A. Delegated Providers

Provide UMP Provider Services a spreadsheet or Provider Profile, in writing or on diskette, that includes the following information. **Provide updates on a monthly basis:**

1. Name and professional degree
2. Gender
3. Date of birth
4. Specialty
5. Social security number
6. DEA number (if applicable)
7. UPIN or NPI number (if applicable)
8. Washington license or certification number
9. Practice location and phone number
10. Billing address information
11. Copy of W-9 form
12. Accepting new patients (yes or no)
13. Advertise in provider directory (yes or no)
14. Obstetric services (yes or no)
15. Optional: Language(s) other than English; after-hours phone number/pager

#### B. Solo and Non-Delegated Providers

Call Provider Services to request a new provider application packet at 1-800-292-8092. Complete and submit the new provider application/provider profile as instructed.

### II. Terminations

Notify Provider Services of termination date of network provider:

**Via e-mail to:** [umpprovider@hca.wa.gov](mailto:umpprovider@hca.wa.gov)

**By mail:**

**Uniform Medical Plan  
P.O. Box 91118  
Seattle, WA 98111-9218**

**By fax: 206-521-2001**

### III. Changes

Notify Provider Services in writing via e-mail, fax, or mail (as shown earlier) of any change of the network provider status—i.e., provider name; address change; tax I.D. change; formal or informal disciplinary actions; Medicare Sanctions; loss of hospital privileges; loss of malpractice coverage, etc.

#### **Process for Updating Specialist Referral Panels** (applies to UMP Neighborhood Care Systems only)

UMP Provider Services will send a monthly report to each Care System with a list of their designated referral providers. Each care system should update this report with any changes (additions, terminations, etc.) and return it to UMP Provider Services promptly.

**Note:** Any changes will be noted in the UMP Neighborhood online directory, which is updated twice a month.